EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JODI GILL, as Representative and Next Friend of GLENN OSCAR GILL, a Long Term Care Facility Resident, on his behalf and on behalf of all others Similarly Situated	:	**No. 20-cv-02038**
	:	**HON. CHAD F. KENNEY**
and	:	
	:	**CLASS ACTION**
GREG HUBERT, as Representative and Next Friend of Nethia Knight, a Long Term Care Facility Resident, on her behalf and on behalf of all others Similarly Situated	:	
Plaintiffs,	:	
v.	:	
PENNSYLVANIA DEPARTMENT OF HEALTH and Rachel Levine, M.D. In Her Official Capacity as Secretary of Health of the Commonwealth of Pennsylvania	:	
Defendants.	:	

DECLARATION OF SARAH BOATENG, EXECUTIVE DEPUTY SECRETARY, PENNSYLVANIA DEPARTMENT OF HEALTH.

I, Sarah Boateng, declare as follows pursuant to 28 U.S. C. § 1746:

BACKGROUND

1. I, Sarah Boateng, am currently employed as the Executive Deputy Secretary for the Pennsylvania Department of Health ("Department"). Prior to that, I served as the special assistant to the Physician General at the Department.

2. I received a master's degree in Healthcare Administration from Colorado State University.

3. The Secretary of Health for the Department is Dr. Rachel Levine, who has served

in that role since 2017. Prior to that, Dr. Levine served as the Physician General of the Commonwealth of Pennsylvania from 2015-2017.

4. Dr. Levine graduated from Harvard College and the Tulane University School of Medicine. She completed her training in Pediatrics and Adolescent Medicine at the Mt. Sinai Medical Center in New York City.

5. Dr. Levine is President of the Association of State and Territorial Health Officials, with her term beginning on September 26, 2019.

THE DEPARTMENT'S RESPONSE TO COVID-19

6. On June 17, 2020, Pennsylvania announced that data from the Centers for Disease Control and Prevention shows the success that Pennsylvania has had in combatting COVID-19, as it is one of only three states to show a downward trajectory of COVID-19 cases for more than 42 days.

7. Virtually all of Pennsylvania has now moved into the "Green Phase," the final stage of Pennsylvania's COVID-19 recovery plan. Every single county in Pennsylvania other than Lebanon County will be in the "Green Phase" as of June 26, 2020.

8. While many states throughout the nation are seeing staggering increases in COVID-19 cases, Pennsylvania has remained focused on the science-based approach it has taken since the outset of the COVID-19 crisis.

9. The Department's actions were based upon the scientific consensus at the time and done solely for the purpose of combatting the COVID-19 pandemic and slowing its spread throughout the Commonwealth of Pennsylvania.

A. INFORMATION AND GUIDELINES ISSUED BY THE DEPARTMENT

10. The Department has disseminated information to Long-Term Care Facility

("LTCF"), which includes Skilled Nursing Facilities ("SNFs"),[1] and the general public, through Health Alert Notices ("HANs"),[2] Guidance documents, press release, and press conferences.

11. The Department does not own or operate any SNFs, including Brighton where Mr. Gill resides.

12. On January 9, 2020, the first HAN was disseminated to providers that instructed all facilities to immediately notify the Department of any patients exhibiting signs of COVID-19. (Ex. A).

13. On January 31, 2020, the Department issued a HAN with specific recommendations for LTCFs. (Ex. B).

14. On February 27, 2020, the Department issued Interim Guidelines for Health Care Professionals that included specific references to infection prevention and control recommendations. (Ex. C).

15. On March 11, 2020, the Department issued a detailed eleven (11) page Guideline on "Infection Prevention and Control Recommendations for Patients with COVID-19 in Healthcare Settings." (Ex. D).

16. These Guidelines explained, *inter alia*, that eye protection, gowns, gloves, and facemasks must be worn and that patients with suspected COVID-19 should be segregated from other patients. (*Id.*)

17. On March 19, 2020 the Department issued more Guidelines, directed specifically at SNFs. (Ex. E).

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[1] Although Plaintiff's Motion uses the term Long-Term Care Facility ("LTCF") in its Motion, Mr. Gill resides in a "Skilled Nursing Facility" ("SNF"), which is just one type of LTCF.

[2] HANs are developed and reviewed by the Department's epidemiologists based on guidance from the Centers for Disease Control and Prevention and the Council of State and Territorial Epidemiologists, which are directed for the provider community.

18. On April 3, 2020, the Department issued another HAN titled "Universal Masking of Health Care Workers and Staff in Congregate Care Settings," in which the Department stated that there should be "universal masking of all persons entering the facility" and daily screening of staff for COVID-19 symptoms. (Ex. F). The Department issued this early and aggressive guidance five (5) days after release of a seminal scientific publication describing spread from asymptomatic persons. For comparison sake, the CDC and the Joint Commission did not make similar recommendations until April 13, 2020 and April 23, 2020, respectively.[3] (Ex.G). This HAN also emphasized other key infection prevention and control measures including the use of a designated unit to care for COVID-19 positive residents with designated staff.

19. On April 14, 2020, the Department issued a HAN regarding the Department's guidance on "cohorting" residents in SNFs, including specific examples of when cohorting is beneficial and when it may lack much value. (Ex. __H). The guidance was developed after consultation with the Centers for Disease Control and Prevention (CDC) subject matter experts in COVID-19 outbreaks in SNFs.

20. On May 12, 2020, the Department issued a HAN regarding "Test-based Strategies for Preventing Transmission of the Virus that Causes COVID-19 in Skilled Nursing Facilities." (Ex. I). This Notice provided extensive training and guidance with respect to the testing and cohorting of residents and staff. (*Id.*)

21. The Department also updated its March 19, 2020 Guidelines in its May 12, 2020 "Interim Guidance for Nursing Care Facilities." (Ex. J). This provided updated information and guidance on cohorting residents, reporting data, visitor policies, and screening of residents and staff. (*Id.*)

[3] The Joint Commission, which is a non-for-profit organization, accredits and certifies more than 22,000 health care organizations and programs in the United States, including nursing care center services.

22. On May 14, 2020 the Department issued an Order directing SNFs to report specific data to further assist the Department in determining and employing the most efficient and practical means for prevention and suppression of COVID-19 within SNFs and to maintain a consistent and constant flow of information between skilled nursing facilities and the Department. (Ex. K). This information is essential in managing the spread of COVID-19 within these facilities and to protect the health and safety of all persons in the Commonwealth. This harmonized data collection with federal (CMS and CDC) initiatives to promote situational awareness and a common operating picture across state and federal response agencies.

23. On June 8, 2020, the Department issued an Order that mandated universal testing of all SNF residents and staff. (Ex. L).

B. RESOURCES, INSTRUCTION, TRAINING, AND INSPECTIONS BY THE DEPARTMENT.

24. In addition to all of the above Guidelines and Notices, the Department has also continued to provide resources, instruction, training, and inspections to the fullest extent possible.

25. Through public/private partnerships and collaboration among state agencies, LTCFs, which includes SNFs, have received over 2,300 deliveries of PPE to date, which has included 306,944 gowns, 336,559 face shields, 1,023,800 gloves, 2,807,570 N95s masks and 1,175,200 surgical masks.

26. The Department is also coordinating with the Pennsylvania Emergency Management Agency ("PEMA") and the Pennsylvania National Guard to provide these supplies to the LTCFs, including SNFs, to train and assist facility staff with testing, and to provide access to the Department's public health laboratory, in the Bureau of Laboratories.

27. The Department also conducted nearly 1,500 inspections at SNFs homes from February through April, as specified below. Inspections may include a combination of building

safety surveys, patient care surveys and complaint investigations.

a. February: 450 surveys of 314 separate facilities; 119 building safety surveys; 331 patient care surveys; and 288 complaint investigations.

b. March: 537 surveys of 359 separate facilities; 150 building safety surveys; 387 patient care surveys; and 321 complaint investigations.

c. April: 486 surveys of 336 separate facilities; 113 building safety surveys; 373 patient care surveys; and 298 complaint investigations.[4]

28. In addition, the Department has assisted the Commonwealth's deployment of 69 Pennsylvania National Guard Strike Teams to 34 different LTCFs, which included, *inter alia*: 32 site assessments, 10 PPE trainings, 13 COVID-19 mass testing missions, and 14 facility staffing missions.

29. The U.S. Public Health Service has also been deployed to 19 facilities for onsite assessments and training.

30. The Department has responded to 100% of outbreaks in SNFs, including proactive outreach by the team of field epidemiologists to begin consultation on proper infection control practices.

31. The Department co-leads an interagency Pennsylvania Assessment and Support Team ("PAST") which leverages multiple state agencies' efforts, including the Pennsylvania Emergency Management Agency (PEMA), Pennsylvania Department of Human Services, the Pennsylvania National Guard, and private contractors (e.g., GHR, CVS Health, Eurofins) to:

a. Conduct infection control assessments;

b. Provide in-person infection control, PPE training and fit-testing;

[4] More recent data is not yet available as the Department does not post data on surveys until 41 days after the survey exit date.

c. Provide critically needed staffing support in LTCFs where staff have been impacted by their own illness or quarantine;

d. Assist facilities in performing universal testing to respond to outbreaks, detect asymptomatic cases and comply with the Secretary's Order, including provision of testing materials and lab support, collecting specimens from residents and staff and training healthcare personnel on how to conduct mass testing in their facility; and

e. Collect specimens from residents and staff to complete.

32. To date, PSAT has prevented the evacuation of 10 LTCFs by supplementing their staffing by directly providing more than 150 facility-days of direct staffing for patient care. PAST has also trained over 1,250 providers, including SNFs, in proper infection control, PPE use, best practices for specimen collection and packaging, and data management. These trainings were provided on-site on every shift and with direct staffing assistance. At each mass testing mission with which we assist, we train the facility on best practices for specimen collection, packaging and data management so that they can complete the testing again on their own

33. The Department is coordinating and overseeing the testing, contact tracing, isolation, resident monitoring, cohorting, and/or quarantine of residents and staff.

34. As set forth *supra*, on June 8, 2020, the Department issued an Order that mandated universal testing of all SNF residents and staff. (Ex. L). The Department is providing technical, material, staffing and laboratory support to complete universal testing consistent with the Secretary's order.

35. To further assist, the Department has executed a contract with CVS Health a comprehensive testing solution, providing, supplies, specimen collection, analysis and reporting. The Department also executed a contract with Eurofins to provide additional overflow capacity.

All results will be provided to the facility and to the Department. Moreover, CMS has announced that COVID-19 testing will be covered under for Medicaid and Medicare residents.

36. The Department's Bureau of Laboratories has processed over seven thousand specimens associated with testing at SNFs; second only to a large national laboratory among the 250 laboratories that have submitted specimens from SNFs to date.

37. To date, over 150 facilities have reported completing universal testing.

38. The Department provides assistance to every SNF with an outbreak, defined as a single case in a resident or staff member. The Department coordinates with the facility to perform contact tracing, isolate and quarantine positive and exposed persons. Facilities can request assistance with universal testing at ra-dhcovidtesting@pa.gov. To date, the Department shipped over 76,000 specimen collection kits to more than 200 SNFs.

39. The Department, in conjunction with federal, state, local and contracted resources has provided extensive remote and in-person educational opportunities for care of residents and training, including train-the-trainer opportunities. The Department coordinated with counties and regional emergency management task forces and medical reserve corps for infection control assessments, staffing and crisis mental health missions. The Department contracted with Cocciardi & Associates to provide fit-testing and train-the-trainer respiratory protection program training for nearly 300 long-term care directors of nursing, administrators and Department surveyors.

40. Again, the Department's actions were based upon the scientific consensus at the time and done solely for the purpose of combatting the COVID-19 pandemic and slowing its spread throughout the Commonwealth of Pennsylvania.

41. I declare the foregoing is true and correct under penalty of perjury.

Dated: June 26, 2020

/s/
SARAH BOATENG

EXHIBIT A

PENNSYLVANIA DEPARTMENT OF HEALTH
2019– PAHAN –471– 01-09 - ADV
Outbreak of Pneumonia of Unknown Etiology (PUE) in Wuhan, China

DATE:	**January 9, 2020**
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**Outbreak of Pneumonia of Unknown Etiology (PUE) in Wuhan, China**
DISTRIBUTION:	Statewide
LOCATION:	Statewide
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a "Health Advisory" provides important information for a specific incident or situation; may not require immediate action.

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, INFECTION CONTROL, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL
EMS COUNCILS: PLEASE DISTRIBUTE AS APPROPRIATE
FQHCs: PLEASE DISTRIBUTE AS APPROPRIATE
LOCAL HEALTH JURISDICTIONS: PLEASE DISTRIBUTE AS APPROPRIATE
PROFESSIONAL ORGANIZATIONS: PLEASE DISTRIBUTE TO YOUR MEMBERSHIP

The Pennsylvania Department of Health (DOH) is forwarding the following advisory to healthcare providers, **"Outbreak of Pneumonia of Unknown Etiology (PUE) in Wuhan, China"** from the Centers for Disease Control and Prevention (CDC). Please report any suspected cases of **PUE immediately** by calling DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
January 8, 2020, 1615 ET (04:15 PM ET)
CDCHAN-00424

Outbreak of Pneumonia of Unknown Etiology (PUE) in Wuhan, China

Summary
The Centers for Disease Control and Prevention (CDC) is closely monitoring a reported cluster of pneumonia of unknown etiology (PUE) with possible epidemiologic links to a large wholesale fish and live animal market in Wuhan City, Hubei Province, China. An outbreak investigation by local officials is ongoing in China; the World Health Organization (WHO) is the lead international public health agency. Currently, there are no known U.S. cases nor have cases been reported in countries other than China. CDC has established an Incident Management Structure to optimize domestic and international coordination if additional public health actions are required. This HAN Advisory informs state and local health departments and health care providers about this outbreak and requests that health care providers ask patients with severe respiratory disease about travel history to Wuhan City. Wuhan City is a major transportation hub about 700 miles south of Beijing with a population of more than 11 million people.

Background
According to a report from the Wuhan Municipal Health Commission, as of January 5, 2020, the national authorities in China have reported 59 patients with PUE to WHO. The patients had symptom onset dates from December 12 through December 29, 2019. Patients involved in the cluster reportedly have had fever, dyspnea, and bilateral lung infiltrates on chest radiograph. Of the 59 cases, seven are critically ill, and the remaining patients are in stable condition. No deaths have been reported and no health care providers have been reported to be ill. The Wuhan Municipal Health Commission has not reported human-to-human transmission.

Reports indicate that some of the patients were vendors at the Wuhan South China Seafood City (South China Seafood Wholesale Market) where, in addition to seafood, chickens, bats, marmots, and other wild animals are sold, suggesting a possible zoonotic origin to the outbreak. The market has been closed for cleaning and disinfection. Local authorities have reported negative laboratory test results for seasonal influenza, avian influenza, adenovirus, severe acute respiratory syndrome-associated coronavirus (SARS-CoV), and Middle East respiratory syndrome coronavirus (MERS-CoV) among patients associated with this cluster. Additional laboratory testing is ongoing to determine the source of the outbreak. Health authorities are monitoring more than 150 contacts of patients for illness.
CDC has issued a level 1 travel notice ("practice usual precautions") for this destination. (https://wwwnc.cdc.gov/travel/notices/watch/pneumonia-china). On January 5, 2020, WHO posted an update on this situation, including an early risk assessment, which is available at: https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/.

Recommendations for Health Care Providers
1. Providers should consider pneumonia related to the cluster for patients with severe respiratory symptoms who traveled to Wuhan since December 1, 2019 and had onset of illness within two weeks of returning, *and* who do not have another known diagnosis that would explain their illness. Providers should notify infection control personnel and local and state health departments immediately if any patients meet these criteria. State health departments should notify CDC after identifying a case under investigation by calling CDC's Emergency Operations Center at (770) 488-7100.
2. Multiple respiratory tract specimens should be collected from persons with infections suspected to be associated with this cluster, including nasopharyngeal, nasal, and throat swabs. Patients with severe respiratory disease also should have lower respiratory tract specimens collected, if possible. Consider saving urine, stool, serum, and respiratory pathology specimens if available.
3. Although the etiology and transmissibility have yet to be determined, and to date, no human-to-human transmission has been reported and no health care providers have been reported ill, CDC currently recommends a cautious approach to symptomatic patients with a history of travel to Wuhan City. Such patients should be asked to wear a surgical mask as soon as they are identified and be evaluated in a private room with the door closed. Personnel entering the room to evaluate the patient should use contact precautions and wear an N95 disposable facepiece respirator. For patients admitted for inpatient care, contact and airborne isolation precautions, in addition to standard precautions, are recommended until further information becomes available. For additional information see: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

This guidance will be updated as more information becomes available.

Please report any suspected cases of **PUE immediately** by calling DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

Categories of Health Alert messages:

Health Alert: conveys the highest level of importance; warrants immediate action or attention.
Health Advisory: provides important information for a specific incident or situation; may not require immediate action.
Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of January 9, 2020 but may be modified in the future.

EXHIBIT B

PENNSYLVANIA DEPARTMENT OF HEALTH
2020– PAHAN - 475 – 1-31-ADV
2019 Novel Coronavirus (2019-nCoV) Interim Guidance for Healthcare Professionals

DATE:	1/31/2020
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**2019 Novel Coronavirus (2019-nCoV) Interim Guidance for Healthcare Professionals**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a "Health Advisory": provides important information for a specific incident or situation; may not require immediate action.

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL**; EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS**: PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF IN YOUR FACILITY

The Pennsylvania Department of Health is releasing updated guidance from the Centers for Disease Control and Prevention (CDC), including criteria for evaluation of travelers from affected areas in China.

- An important change from previous guidance is that **travelers from China elsewhere than Wuhan City** who develop illness need to be evaluated:
  - **Hubei Province**, with fever and signs of lower respiratory illness; or
  - **Mainland China**, with fever and signs of lower respiratory illness requiring hospitalization
- Health care providers should contact the Pennsylvania Department of Health at 1-877-PA- HEALTH or local health department about possible cases of the 2019 novel Coronavirus
- Clinical specimens should be collected from Patients under Investigation (PUIs) for routine testing of respiratory pathogens at either clinical or public health labs
- Testing at the PA DOH Bureau of Laboratories and/or Centers for Disease Control and Prevention (CDC) must be approved by PA DOH Bureau of Epidemiology
- Specimens cannot be sent to CDC until a CDC nCoV ID number has been issued

Interim Guidance for Healthcare Professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html)

Limited information is available to characterize the spectrum of clinical illness associated with 2019 novel coronavirus (2019-nCoV). No vaccine or specific treatment for 2019-nCoV infection is available; care is supportive.

The CDC clinical criteria for a 2019-nCoV patient under investigation (PUI) have been developed based on what is known about MERS-CoV and SARS-CoV and are subject to change as additional information becomes available.

Health care providers should obtain a detailed travel history for patients being evaluated with fever and acute respiratory illness. CDC guidance for evaluating and reporting a PUI for MERS-CoV remains unchanged.

Criteria to Guide Evaluation of Patients Under Investigation (PUI) for 2019-nCoV
Patients in the United States who meet the following criteria should be evaluated as a PUI for 2019-nCoV.

Clinical Features	&	Epidemiologic Risk
Fever[1] **o**r signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers, who has had close contact[2] with a laboratory-confirmed[3,4] 2019-nCoV patient within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization[4]	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).

Interim Clinical Guidance for Management of Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) Infection, Updated January 30, 2020
(https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html)
This interim guidance is for clinicians caring for patients with confirmed 2019 novel coronavirus (2019-nCoV) infection. CDC will update this interim guidance as more information becomes available.

Clinical Presentation
There are a limited number of reports that describe the clinical presentation of patients with confirmed 2019-nCoV infection, and most are limited to hospitalized patients with pneumonia. The incubation period is estimated at ~5 days (95% confidence interval, 4 to 7 days). Frequently reported signs and symptoms include fever (83–98%), cough (76%–82%), and myalgia or

fatigue (11–44%) at illness onset. Sore throat has also been reported in some patients early in the clinical course. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. The fever course among patients with 2019-nCoV infection is not fully understood; it may be prolonged and intermittent. Asymptomatic infection has been described in one child with confirmed 2019-nCoV infection and chest computed tomography (CT) abnormalities.

Risk factors for severe illness are not yet clear, although older patients and those with chronic medical conditions may be at higher risk for severe illness. Nearly all reported cases have occurred in adults (median age 59 years). In one study of 425 patients with pneumonia and confirmed 2019-nCoV infection, 57% were male. Approximately one-third to one-half of reported patients had underlying medical comorbidities, including diabetes, hypertension, and cardiovascular disease.

Clinical Course

Clinical presentation among reported cases of 2019-nCoV infection varies in severity from asymptomatic infection or mild illness to severe or fatal illness. Some reports suggest the potential for clinical deterioration during the second week of illness. In one report, among patients with confirmed 2019-nCoV infection and pneumonia, just over half of patients developed dyspnea a median of 8 days after illness onset (range: 5–13 days).

Acute respiratory distress syndrome (ARDS) developed in 17–29% of hospitalized patients, and secondary infection developed in 10%. Between 23–32% of hospitalized patients with 2019-nCoV infection required intensive care for respiratory support. Some hospitalized patients have required advanced organ support with invasive mechanical ventilation (4–10%), and a small proportion have also required extracorporeal membrane oxygenation (ECMO, 3–5%). Other reported complications include acute cardiac injury (12%) and acute kidney injury (4–7%). Among hospitalized patients with pneumonia, the case fatality proportion has been reported as high as 11–15%. However, as this estimate includes only-hospitalized patients, and therefore is biased upward.

Diagnostic Testing

Currently, confirmation of 2019-nCoV infection is performed at CDC using the CDC real-time RT-PCR assay for 2019-nCoV on respiratory specimens (which can include nasopharyngeal or oropharyngeal aspirates or washes, nasopharyngeal or oropharyngeal swabs, broncheoalveolar lavage, tracheal aspirates, or sputum) and serum. Information on specimen collection, handling, and storage is available at: Real-Time RT-PCR Panel for Detection 2019-Novel Coronavirus. After initial confirmation of 2019-nCoV infection, additional testing of clinical specimens can help inform clinical management, including discharge planning.

Laboratory and Radiographic Findings

The most common laboratory abnormalities reported among hospitalized patients with pneumonia on admission included leukopenia (9–25%), leukocytosis (24–30%), lymphopenia (63%), and elevated alanine aminotransferase and aspartate aminotransferase levels (37%). Most patients had normal serum levels of procalcitonin on admission. Chest CT images have shown bilateral involvement in most patients. Multiple areas of consolidation and ground glass opacities are typical findings reported to date.

2019-nCoV RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid. The duration of shedding of 2019-nCoV RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer, which has been observed in cases of MERS-CoV or SARS-CoV infection.

Clinical Management and Treatment

No specific treatment for 2019-nCoV infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated. Corticosteroids should be avoided unless indicated for other reasons (for example, chronic obstructive pulmonary disease exacerbation or septic shock per Surviving Sepsis guidelines, because of the potential for prolonging viral replication as observed in MERS-CoV patients. For more information, see: WHO interim guidance on clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected and Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America.

Healthcare personnel should care for patients in an Airborne Infection Isolation Room (AIIM). Standard Precautions, Contact Precautions, and Airborne Precautions and eye protection should be used when caring for the patient. See Interim Health Care Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus.

Patients with a mild clinical presentation may not initially require hospitalization. However, clinical signs and symptoms may worsen with progression to lower respiratory tract disease in the second week of illness; all patients should be monitored closely. Possible risk factors for progressing to severe illness may include, but are not limited to, older age, and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend not only on the clinical presentation, but also on the patient's ability to engage in monitoring and the risk of transmission in the patient's home environment. For more information, see Criteria to Guide Evaluation of Patients Under Investigation (PUI) for 2019-nCoV.

Additional resources:

- Interim Guidance for Healthcare Professionals.
- Resources for Hospitals and Healthcare Professionals Preparing for Patients with Suspected or Confirmed 2019-nCoV
- Interim Health Care Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus
- World Health Organization. Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected
- American Thoracic Society and Infectious Diseases Society of America Clinical Practice Guidelines. Diagnosis and treatment of adults with community-acquired pneumonia
- Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016
- Clinical Practice Guidelines by the Infectious Diseases Society of America: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza

References

Available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

Footnotes

[1]Fever may be subjective or confirmed

[2]Close contact is defined as—

a) being within approximately 6 feet (2 meters), or within the room or care area, of a 2019-nCoV case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a 2019-nCoV case – or –

b) having direct contact with infectious secretions of a 2019-nCoV case (e.g., being coughed on) while not wearing recommended personal protective equipment.

See CDC's updated Interim Healthcare Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus.

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with 2019-nCoV (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

[3]Documentation of laboratory-confirmation of 2019-nCoV may not be possible for travelers or persons caring for patients in other countries.

[4]Category also includes any member of a cluster of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which 2019-nCoV is being considered that requires hospitalization. Such persons should be evaluated in consultation with state and local health departments regardless of travel history.

Please report any suspected cases of the **2019 novel Coronavirus** by calling DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

Categories of Health Alert messages:

Health Alert: conveys the highest level of importance; warrants immediate action or attention.

Health Advisory: provides important information for a specific incident or situation; may not require immediate action.

Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of January 31, 2020, but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

EXHIBIT C

PENNSYLVANIA DEPARTMENT OF HEALTH
2020– PAHAN - 479 – 02-27-ALT

COVID-19 Interim Guidance for Healthcare Professionals

DATE:	2/27/2020
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**COVID-19 Interim Guidance for Healthcare Professionals**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a "Health Alert", conveys the highest level of importance; warrants immediate action or attention.

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL**; EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS**: PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF IN YOUR FACILITY

The Pennsylvania Department of Health (DOH) is releasing the following, "**COVID-19 Interim Guidance for Healthcare Professionals**."

- An important change from previous guidance is that travelers from newly affected geographic areas (in bold) who develop illness need to be evaluated, including:
  - China
  - **Iran**
  - **Italy**
  - **Japan**
  - **South Korea**
- Health care providers should contact the Pennsylvania Department of Health at 1-877-PA-HEALTH or local health department about possible cases of coronavirus disease (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2, shortened to SARS-CoV-2
- Clinical specimens should be collected from Patients under Investigation (PUIs) for routine testing of respiratory pathogens at either clinical or public health labs
- Testing at the PA DOH Bureau of Laboratories (BOL) and/or Centers for Disease Control and Prevention (CDC) must be approved by PA DOH Bureau of Epidemiology
- Specimens cannot be sent to CDC until a CDC nCoV ID number has been issued

Evaluating and Reporting Persons Under Investigation (PUI)

Summary of Recent Changes

Revisions were made on February 27, 2020, to reflect the following:

- Information updated in the “Criteria to Guide Evaluation of PUI for COVID-19” section.

Updated February 27, 2020

Limited information is available to characterize the spectrum of clinical illness associated with coronavirus disease 2019 (COVID-19). No vaccine or specific treatment for COVID-19 is available; care is supportive.

The CDC clinical criteria for a COVID-19 person under investigation (PUI) have been developed based on what is known about MERS-CoV and SARS-CoV and are subject to change as additional information becomes available.

Healthcare providers should obtain a detailed travel history for patients being evaluated with fever and acute respiratory illness. CDC guidance for evaluating and reporting a PUI for MERS-CoV remains unchanged.

Criteria to Guide Evaluation of PUI for COVID-19

DOH and local health departments, in consultation with clinicians, should determine whether a patient is a PUI for COVID-2019. The CDC clinical criteria for COVID-19 PUIs have been developed based on available information about this novel virus, as well as what is known about Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). These criteria are subject to change as additional information becomes available.

Clinical features and epidemiologic risk		
Clinical Features	**&**	**Epidemiologic Risk**
Fever[1] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from affected geographic areas[5] within 14 days of symptom onset
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)[6]	**AND**	No source of exposure has been identified

Affected Geographic Areas with Widespread or Sustained Community Transmission
Last updated February 26, 2020

- **China**
- **Iran**
- **Italy**
- **Japan**
- **South Korea**

See all COVID-19 Travel Health Notices.

The criteria are intended to serve as guidance for evaluation. In consultation with DOH or their local health department, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.

Recommendations for Reporting, Testing, and Specimen Collection

Healthcare providers should **immediately** notify both infection control personnel at their healthcare facility and DOH or their local health department in the event of a PUI for COVID-19. **Please call DOH (877-PA-HEALTH) or your local health department to discuss any possible exposures**.

Testing for other respiratory pathogens should not delay specimen shipping to the Pennsylvania Department of Health Bureau of Labs (BOL). If a PUI tests positive for another respiratory pathogen, after clinical evaluation and consultation with public health authorities, they may no longer be considered a PUI. This may evolve as more information becomes available on possible COVID-19 co-infections.

For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for COVID-19.

To increase the likelihood of detecting COVID-19, CDC and DOH recommend collecting and testing multiple clinical specimens from different sites, including two specimen types—lower respiratory and upper respiratory. Additional specimen types (e.g., stool, urine) may be collected and stored. Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset. Additional guidance for collection, handling, and testing of clinical specimens is available.

Interim Healthcare Infection Prevention and Control Recommendations for Persons Under Investigation for COVID-19

- Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings
- Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
- CDC Health Alert Network Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)

Footnotes

[1]Fever may be subjective or confirmed

[2]For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation

[3]Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

See CDC's updated Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings.

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19.

[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for patients in other countries.

[5] Affected areas are defined as geographic areas where sustained community transmission has been identified. Relevant affected areas will be defined as a country with sustained or widespread community-level transmission (CDC Level 2 or 3 Travel Health Notice).

[6] Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which COVID-19 is being considered.

Additional Resources:

- World Health Organization (WHO) Coronavirus

WHO guidance on clinical management of severe acute respiratory infection when COVID-19 is suspected

Categories of Health Alert messages:
Health Alert: conveys the highest level of importance; warrants immediate action or attention.
Health Advisory: provides important information for a specific incident or situation; may not require immediate action.
Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of February 27, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

EXHIBIT D

PENNSYLVANIA DEPARTMENT OF HEALTH
2020 – PAHAN – 486 – 03-11-ALT

pennsylvania DEPARTMENT OF HEALTH

Alert: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings

DATE:	3/11/2020
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**Interim Infection Prevention and Control Recommendations for Patients with COVID-19 in Healthcare Settings**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a "Health Alert", conveys the highest level of importance; warrants immediate action or attention.

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The Pennsylvania Department of Health (DOH) is releasing the following updates based on guidance released by the Centers for Disease Control and Prevention (CDC) on March 10, 2020, for infection prevention and control recommendations for patients with suspected or confirmed COVID-19 in healthcare settings.

- Based on local and regional situational analysis of PPE supplies, facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand
- Prioritize available respirators for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to HCP
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators
- Eye protection, gown, and gloves continue to be recommended in addition to masks
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients
- Place a patient with known or suspected COVID-19 in a single-person room with the door closed with a dedicated bathroom. Reserve Airborne Infection Isolation Rooms (AIIRs) for patients who will be undergoing aerosol-generating procedures
- Implement source control by putting a facemask over the mouth and nose of a person with respiratory symptoms
- If you have specific questions on infection control measures in addition to these guidelines, call DOH at **1-877-PA-HEALTH** (**1-877-724-3258**)

Updated PPE recommendations for the care of patients with known or suspected COVID-19:

- Based on local and regional situational analysis of PPE supplies, facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to HCP.
    - Facemasks protect the wearer from splashes and sprays.
    - Respirators, which filter inspired air, offer respiratory protection.
- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Facilities that do not currently have a respiratory protection program, but care for patients infected with pathogens for which a respirator is recommended, should implement a respiratory protection program.
- Eye protection, gown, and gloves continue to be recommended.
    - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP.
- Included are considerations for designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients and options for extended use of respirators, facemasks, and eye protection on such units. Updated recommendations regarding need for an airborne infection isolation room (AIIR).
    - Patients with known or suspected COVID-19 should be cared for in a single-person room with the door closed. Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients undergoing aerosol-generating procedures (See Aerosol-Generating Procedures Section)
- Updated information in the background is based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), and gowns.
    - Increased emphasis on early identification and implementation of source control (i.e., putting a face mask on patients presenting with symptoms of respiratory infection).
- If you have specific questions on infection control measures in addition to these guidelines, call DOH at **1-877-PA-HEALTH** (**1-877-724-3258**)

Background

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), and gowns. Here is what is currently known:

Mode of transmission: Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely.

Shortage of personal protective equipment: Controlling exposures to occupational infections is a fundamental method of protecting HCP. Traditionally, a hierarchy of controls has been used as a means of determining how to implement feasible and effective control solutions. The hierarchy ranks controls according to their reliability and effectiveness and includes such controls as engineering controls, administrative controls, and ends with personal protective equipment (PPE). PPE is the least effective control because it involves a high level of worker involvement and is highly dependent on proper fit and correct, consistent use.

Major distributors in the United States have reported shortages of PPE, specifically N95 respirators, facemasks, and gowns. Healthcare facilities are responsible for protecting their HCP from exposure to pathogens, including by providing appropriate PPE.

In times of shortages, alternatives to N95s should be considered, including other classes of FFRs, elastomeric half-mask and full facepiece air purifying respirators, and powered air purifying respirators (PAPRs) where feasible. Special care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important, such as performance of aerosol-generating procedures on suspected or confirmed COVID-19 patients or provision of care to patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella).

The anticipated timeline for return to routine levels of PPE is not yet known. Information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are in limited supply and a companion checklist to help healthcare facilities prioritize the implementation of the strategies, is available.

Capacity across the healthcare continuum: Use of N95 or higher-level respirators are recommended for HCP who have been medically cleared, trained, and fit-tested, in the context of a facility's respiratory protection program. The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not have respiratory protection programs nor have they fit-tested HCP, hampering implementation of recommendations in the previous version of this guidance. This can lead to unnecessary transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care. In areas with community transmission, acute care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.

Many of the recommendations described in this guidance (e.g., triage procedures, source control) should already be part of an infection control program designed to prevent transmission of seasonal respiratory infections. As it will be challenging to distinguish COVID-19 from other respiratory infections, interventions will need to be applied broadly and not limited to patients with confirmed COVID-19.

This guidance is applicable to all U.S. healthcare settings. **This guidance is not intended for non-healthcare settings (e.g., schools) OR for persons outside of healthcare settings.** For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC COVID-19 website.

Definition of Healthcare Personnel (HCP) –For the purposes of this document, HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Recommendations

1. Minimize Chance for Exposures

Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Measures should be implemented before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected. It is particularly important to protect individuals at increased risk for adverse outcomes from COVID-19 (e.g. older individuals with comorbid conditions), including HCP who are in a recognized risk category.

- **Before Arrival**
  - When scheduling appointments for routine medical care (e.g., annual physical, elective surgery), instruct patients to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (e.g., cough, sore throat, fever[1]) on the day they are scheduled to be seen.

- When scheduling appointments for patients requesting evaluation for a respiratory infection, use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home.
  - If the patient must come in for an appointment, instruct them to call beforehand to inform triage personnel that they have symptoms of a respiratory infection (e.g., cough, sore throat, fever[1]) and to take appropriate preventive actions (e.g., follow triage procedures, wear a facemask upon entry and throughout their visit or, if a facemask cannot be tolerated, use a tissue to contain respiratory secretions).
- If a patient is arriving via transport by emergency medical services (EMS), EMS personnel should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.

- **Upon Arrival and During the Visit**
  - Consider limiting points of entry to the facility.
  - Take steps to ensure all persons with symptoms of COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette (see appendix), hand hygiene, and triage procedures throughout the duration of the visit.
    - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
    - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
    - Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
    - Consider establishing triage stations outside the facility to screen patients before they enter.
  - Ensure rapid safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough).
    - Prioritize triage of patients with respiratory symptoms.
    - Triage personnel should have a supply of facemasks and tissues for patients with symptoms of respiratory infection. These should be provided to patients with symptoms of respiratory infection at check-in. Source control (putting a facemask over the mouth and nose of a symptomatic patient) can help to prevent transmission to others.
    - Ensure that, at the time of patient check-in, all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVID-19 or contact with possible COVID-19 patients.
    - Isolate the patient in an examination room with the door closed. If an examination room is not readily available ensure the patient is not allowed to wait among other patients seeking care.
      - Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.
      - In some settings, patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.
  - Incorporate questions about new onset of respiratory symptoms into daily assessments of all admitted patients. Monitor for and evaluate all new fevers and respiratory illnesses among patients. Place any patient with unexplained fever or respiratory symptoms on appropriate Transmission-Based Precautions and evaluate.

Additional considerations during periods of community transmission:

- Explore alternatives to face-to-face triage and visits.
- Learn more about how healthcare facilities can Prepare for Community Transmission
- Designate an area at the facility (e.g., an ancillary building or temporary structure) or identify a location in the area to be a "respiratory virus evaluation center" where patients with fever or respiratory symptoms can seek evaluation and care.
- Cancel group healthcare activities (e.g., group therapy, recreational activities).
- Postpone elective procedures, surgeries, and non-urgent outpatient visits.

2. Adhere to Standard and Transmission-Based Precautions

Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including COVID-19, are summarized below. Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

HCP (see Section 5 for measures for non-HCP visitors) who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or facemask, gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- **Hand Hygiene**

  - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
  - HCP should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
  - Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.

- **Personal Protective Equipment**

  Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards (29 CFR 1910 Subpart I). HCP must receive training on and demonstrate an understanding of:

  - when to use PPE
  - what PPE is necessary
  - how to properly don, use, and doff PPE in a manner to prevent self-contamination
  - how to properly dispose of or disinfect and maintain PPE
  - the limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with known or suspected COVID-19 includes:

- **Respirator or Facemask**
  - Put on a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.
  - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure (See Section 4). See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator or facemask. For guidance on extended use of respirators, refer to Strategies to Optimize the Current Supply of N95 Respirators
    - If reusable respirators (e.g., powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
  - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program.

- **Eye Protection**
  - Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
  - Remove eye protection before leaving the patient room or care area.
  - Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.
- **Gloves**
  - Put on clean, non-sterile gloves upon entry into the patient room or care area.
    - Change gloves if they become torn or heavily contaminated.
  - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
- **Gowns**
  - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - If there are shortages of gowns, they should be prioritized for:
    - aerosol-generating procedures
    - care activities where splashes and sprays are anticipated
    - high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
      - dressing
      - bathing/showering
      - transferring
      - providing hygiene
      - changing linens
      - changing briefs or assisting with toileting
      - device care or use

- wound care

3. Patient Placement

- For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization. If hospitalization is not medically necessary, home care is preferable if the individual's situation allows.
- If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.
    - Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients who will be undergoing aerosol-generating procedures (See Aerosol-Generating Procedures Section)
- As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients. Dedicated means that HCP are assigned to care only for these patients during their shift.
    - Determine how staffing needs will be met as the number of patients with known or suspected COVID-19 increases and HCP become ill and are excluded from work.
    - It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should not be housed in the same room as a patient with an undiagnosed respiratory infection.
    - During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.
        - HCP must take care not to touch their eye protection and respirator or facemask .
        - Eye protection and the respirator or facemask should be removed, and hand hygiene performed if they become damaged or soiled and when leaving the unit.
    - HCP should strictly follow basic infection control practices between patients (e.g., hand hygiene, cleaning and disinfecting shared equipment).
- Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Consider providing portable x-ray equipment in patient cohort areas to reduce the need for patient transport.
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Patients should wear a facemask to contain secretions during transport. If patients cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose.
- Personnel entering the room should use PPE as described above.
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Whenever possible, perform procedures/tests in the patient's room.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use (See Section 10).

4. Take Precautions When Performing Aerosol-Generating Procedures (AGPs)

- Some procedures performed on patient with known or suspected COVID-19 could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.
- If performed, the following should occur:
    - HCP in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
    - AGPs should ideally take place in an AIIR.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

5. Collection of Diagnostic Respiratory Specimens

- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 patient, the following should occur:
    - HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for specimen collection.
    - Specimen collection should be performed in a normal examination room with the door closed.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

6. Manage Visitor Access and Movement Within the Facility

- Establish procedures for monitoring, managing and training all visitors, which should include:
    - All visitors should perform frequent hand hygiene and follow respiratory hygiene and cough etiquette precautions while in the facility, especially common areas.
    - Passively screen visitors for symptoms of acute respiratory illness before entering the healthcare facility
        - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) advising visitors not to enter the facility when ill.
    - Informing visitors about appropriate PPE use according to current facility visitor policy
    - Visitors to the most vulnerable patients (e.g., oncology and transplant wards) should be limited; visitors should be screened for symptoms prior to entry to the unit.
- Limit visitors to patients with known or suspected COVID-19. Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets. If visitation must occur, visits should be scheduled and controlled to allow for the following:
    - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
    - Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
    - Visitors should not be present during AGPs or other specimen collection procedures.
    - Visitors should be instructed to only visit the patient room. They should not go to other locations in the facility.

Additional considerations during periods of community transmission:

- All visitors should be actively assessed for fever and respiratory symptoms upon entry to the facility. If fever or respiratory symptoms are present, visitor should not be allowed entry into the facility.

- Determine the threshold at which screening of persons entering the facility will be initiated and at what point screening will escalate from passive (e.g., signs at the entrance) to active (e.g., direct questioning) to restricting all visitors to the facility.
- If restriction of all visitors is implemented, facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.
- Limit points of entry to the facility.

7. Implement Engineering Controls

- Design and install engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include:
  - physical barriers or partitions to guide patients through triage areas
  - curtains between patients in shared areas
  - air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained

8. Monitor and Manage Ill and Exposed Healthcare Personnel

- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.
- Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with public health authorities. Refer to the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) for additional information.

9. Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

10. Implement Environmental Infection Control

- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19.
  - All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the Healthcare Infection Prevention and Control FAQs for COVID-19

11. Establish Reporting within and between Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promote situational awareness for facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected COVID-19 patients and facility plans for response.
- Communicate and collaborate with public health authorities.
    - Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- Communicate information about known or suspected COVID-19 patients to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

Appendix:

Additional Information about Airborne Infection Isolation Rooms, Respirators and Facemasks
Information about Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation).
- Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Information about Respirators:

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134). HCP should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- NIOSH information about respirators
- OSHA Respiratory Protection eTool
- Strategies for Optimizing the Supply of N-95 Respirators

Filtering Facepiece Respirators (FFR) including N95 Respirators

- A commonly used respirator in healthcare settings is a filtering facepiece respirator (commonly referred to as an N95). FFRs are disposable half facepiece respirators that filter out particles.
- To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one. This is called "fit-testing" and is usually done in a workplace where respirators are used.
- Three key factors for an N95 respirator to be effective
- FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- Learn more about how to perform a user seal check

- For more information on how to perform a user seal check: https://www.cdc.gov/niosh/docs/2018-130/pdfs/2018-130.pdf?id=10.26616/NIOSHPUB2018130
- NIOSH-approved N95 respirators list.
- PAPRs have a battery-powered blower that pulls air through attached filters, canisters, or cartridges. They provide protection against gases, vapors, or particles, when equipped with the appropriate cartridge, canister, or filter.
- Loose-fitting PAPRs do not require fit testing and can be used with facial hair.
- A list of NIOSH-approved PAPRs is located on the NIOSH Certified Equipment List.

Information about Facemasks:

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).
- Facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for COVID-19
CDC has developed interim guidance for staff at local and state health departments, infection prevention and control professionals, healthcare providers, and healthcare workers who are coordinating the home care and isolation of people who are confirmed to have, or being evaluated for (COVID-19 (see Criteria to Guide Evaluation of Patients Under Investigation (PUI) for COVID-19).
Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization forCOVID-19)

Important Links

- Respirator Trusted-Source Information
- Respirator Fact Sheet

Footnote

1. Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations.

Categories of Health Alert messages:
Health Alert: conveys the highest level of importance; warrants immediate action or attention.
Health Advisory: provides important information for a specific incident or situation; may not require immediate action.
Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of March 11, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

EXHIBIT E

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Interim Guidance for Nursing Facilities During COVID-19 (3/18/20)

The Department of Health has received questions from nursing care facilities, associations, and constituents regarding best practices in nursing homes related COVID-19 including visitation policies. The Department is supporting guidance on critical measures issued by CMS for all nursing facilities, advise that facilities do the following:

- Restrict all visitors, effective immediately, with exceptions for compassionate care, such as during end-of-life situations
- Restrict all volunteers, non-essential health care personnel and other personnel (i.e. barbers);
    - This does not include the following:
        - Home-health and dialysis services;
        - The Department of Aging/Area Agency on Aging and the Department of Human Services *where there is concern for serious bodily injury, sexual abuse, or serious physical injury*; and
        - Hospice services offered by licensed providers within the nursing home facility.
- Restrict cross-over visitation from personal care home (PCH), Assisted Living, and/or Continuing Care Community residents to nursing homes. Ensure cross-over staff adhere to the facility's infection disease protocol.
- When there is evidence of community spread of COVID-19 within your county or adjacent counties, nursing care facilities should cancel all communal activities.
- When there is no community spread of COVID-19 within their county or adjacent counties, facilities should, at a minimum, implement social distancing in dining practices and group activities. The following recommended approaches should be considered:
    - **Testing**
        - Implement active screening of residents and health care personnel for fever and respiratory symptoms (Recommended Screening Questions below);
        - Staff should be screened at the beginning and end of every shift; and
        - Complete a Facility Entry Screening Form for each screening (Template accompanies this guidance)
        - If employees are ill or become ill during their shift, CMS recommends that facilities have employees put on a facemask and end their work shift, leave the building, and self-isolate at home.
    - **Admissions/Discharges**
        - Nursing care facilities must continue to accept new admissions and receive readmissions for current residents who have been discharged from the hospital who are stable to alleviate the increasing burden in the acute care settings. This may include stable patients who have had the COVID-19 virus.
            - Facilities should continuously consult the 2020 Health Alerts, Advisories and Updates for the most current information related to Test of Cure under the title "Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19

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in Healthcare Settings" See: https://www.health.pa.gov/topics/prep/PA-HAN/Pages/2020-HAN.aspx.

- Nursing care facilities should continue to employ normal discharge-to-home criteria to assist in LTC bed availability. If there has been a positive case, then appropriate quarantine measures shall be taken at the direction of the Department of Health of the CDC.

- **Dining services:**
  - Provide in-room meal service for those that are assessed to be capable of feeding themselves without supervision or assistance
  - Identify high-risk choking residents and those at-risk for aspiration who may cough, creating droplets
    - Meals for these residents should be provided in their rooms. If that is not possible then the residents should remain at least six (6) feet or more from others if in a common area for meals, with as few other residents in the common area as feasible during their mealtime
  - If residents are brought to the common area for dining, then the following steps must be taken:
    - Stagger arrival times and maintain social distancing;
    - Attempt to separate tables as far apart as possible; with goal of residents being at least six (6) feet apart;
    - Increase the number of meal services or offer meals in shifts to allow fewer residents in common areas at one time;
    - Have residents sit at tables by themselves to ensure that social distancing between residents can be maintained; and
    - Staff should take appropriate precautions with eye protection and gowns for this high-risk for choking resident population, given the risk to cough while eating.
  - Residents who need assistance with feeding should be spaced apart as much as possible, ideally six (6) feet or more. Where it is not possible to have residents at six feet, than no more than one person per table (assuming a standard four [4] person table).
    - Staff members who are providing assistance for more than one resident simultaneously must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents.

- **Communal Activities**
  - Do not engage in communal activities unless doing so is necessary to maintain the health and welfare of the residents;
  - When there is evidence of community spread of COVID-19 within your county or adjacent counties, nursing care facilities should cancel all group activities and communal dining; and
  - If engaging in communal activities, only do so where a 6-foot separation can be maintained.

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- The following applies to any communal activities:
    - A resident can attend only if the resident has no fever or respiratory symptoms. – This requires the facility to perform evaluations as transporting to activity or as patients enter room;
    - The activity does not include food prep;
    - During the activity there are no shared bowls of food or containers of drinks (bottles or shared pitchers) such as pretzels, popcorn etc. If snacks are served, they must be individually wrapped, or drinks poured and served by staff;
    - No games where cards or game pieces would be passed between residents; and
    - Avoid group singing activities.

- OTHER
    - The infection control specialists designated by the facility must review PPE guidelines with all staff;
    - Minimize resident interactions with service providers (e.g. plumbers, electricians, etc.) through actions such as use of separate entrances, performing service at off-hours, and perform only essential servicing activities;
    - Arrange for deliveries to areas where there is limited person-to-person interaction;
    - Evaluate environmental cleaning practices and consider increasing frequency for high-tough surfaces; and
    - Remain adaptable, creative and supportive of all staff working in this pandemic situation.

The Centers for Medicare and Medicaid Services (CMS) provided additional guidance to nursing facilities to actively take employees temperature and document absence of shortness of breath, new or change in cough, and sore throat. If employees are ill or become ill during their shift, CMS recommends that facilities have employees put on a facemask and end their work shift, leave the building, and self-isolate at home.

Facilities should identify staff that work at multiple facilities and restrict them if appropriate, based on any knowledge of exposure to COVID-19 of residents in those facilities.

This is **immediately applicable to all nursing facilities in Pennsylvania**.

Please refer to the Department's website for the most up-to-date information.
Reference: https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf

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Recommended Screening Questions1:

All individuals entering the nursing home should be asked the following questions:

1. Has this individual washed their hands or used alcohol-based hand rub on entry?
   YES / NO – If no, please have them to do so

2. Ask the individual if they have any of the following respiratory symptoms?
   Fever
   Sore throat
   Cough
   Shortness of breath

   If YES to any of the above, restrict the individual from entering the nursing home.
   If NO to all of the above, proceed to question #3 for employees and step #4 for all others.

3A. For employees, you may check the employee's temperature and document results
   Fever (defined as temperature greater than or equal to 100.0 degrees Fahrenheit) present?

   If YES, restrict the individual from entering the nursing home.
   If NO, proceed to step 3B.

3B. For employees, ask if they have:
   Worked in facilities with recognized COVID-19 cases?

   If YES, ask if they worked with a person with confirmed COVID-19?
   YES/NO
   If YES, restrict them from entering the nursing home.
   If NO, proceed to step 4.

4. For visitors who are allowed to visit due to compassionate care situations *and are asymptomatic upon screening*, allow entry to the nursing home and remind the individual to:
   - Wash their hands or use alcohol-based hand rub throughout their time in the nursing home;
   - Not shake hands with, touch or hug individuals while in the nursing home;
   - Wear a facemask while in the nursing home and
   - Restrict their visit to the resident's room or other location designated by the facility.

1 American Healthcare Facilities Association

EXHIBIT F

PENNSYLVANIA DEPARTMENT OF HEALTH
2020 – PAHAN – 492 – 4-3-ALT
ALERT: Universal Masking of Healthcare Workers and Staff in Congregate Care Settings

pennsylvania DEPARTMENT OF HEALTH

DATE:	4/3/2020
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**ALERT: Universal Masking of Health Care Workers and Staff in Congregate Care Settings**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a "Health Alert": conveys the highest level of importance; warrants immediate action or attention.

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL**; EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS**: PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF IN YOUR FACILITY

Minimizing transmission of COVID-19 into and within health care facilities and congregate care facilities is critical.

- Implement universal masking of all persons (e.g., staff members) entering the facility with a surgical or isolation mask (not a respirator). If possible, symptomatic patients or residents should be masked during direct care to enhance source control.
- Facilities should continue to implement daily symptom screening for all staff and restrict visitors, including visits from non-essential ancillary therapeutic services.
- Continue to utilize recommended PPE (N-95 respirator or higher, gown, gloves, and eye protection) for confirmed COVID-19 cases.
- Implement strategies to optimize the supply of PPE and equipment.

There are an increasing number of COVID-19 cases among staff and residents of skilled nursing facilities and other congregate care settings. This is particularly concerning since congregate health care settings serve persons at highest risk for severe disease due to COVID-19. Outbreaks are occurring in these settings, despite aggressive measures to prevent the introduction of COVID-19 into facilities and transmission within facilities. To minimize the risk of transmission, the Pennsylvania Department of Health (DOH) strongly recommends the following steps in addition to current infection prevention and control strategies.

Universal Masking of HCWs and Staff —Infection Prevention and Control of COVID-19 in Congregate Care Settings:

1. **Universal Masking**
   Implement universal masking of all persons entering the facility. Prioritize mask use and implement strategies to optimize the supply of PPE and equipment.

   As the supply chain permits, continue to use recommended PPE (N-95 respirator or higher, gown, gloves, and eye protection) for confirmed COVID-19 cases and aerosol generating procedures.

   When available, HCWs should wear commercially available surgical or isolation masks (not a respirator) unless providing direct patient care to confirmed COVID-19 cases (as noted above).

   Staff members not providing direct patient care should also be masked with a commercially available surgical or isolation mask if available.

   Symptomatic patients or residents should also be masked during direct care, if possible.

   In settings where facemasks are not available, HCWs and other staff might use homemade masks; however, homemade masks are not considered PPE, since their capability to protect HCW is unknown. Nonetheless, this recommendation is being issued as a layered approach to other infection prevention and mitigation strategies to reduce transmission when the mask is worn by a symptomatic or asymptomatic person (i.e., source control; “My mask protects you; your mask protects me.”)

Universal Masking is Only One Part of a Comprehensive Strategy, Including:

2. **Daily Symptom Screening of Staff**
   All staff should be screened for fever (100F or greater) through temperature monitoring and for any respiratory symptoms, including cough, sore throat or shortness of breath, at the beginning and end of their work shift. Staff reporting any of these symptoms should be immediately sent home.

3. **Visitor Restriction**
   Adhere to strict visitor restrictions, including visits from non-essential ancillary therapeutic services (e.g., physical therapy) that can be safely suspended.

4. **SARS-CoV-2 Testing**
   Do not perform routine laboratory testing of asymptomatic staff or residents for COVID-19 (unless instructed by DOH to do so). Follow guidance in March 9 HAN regarding work exclusions after health care-associated exposures; facilities will need to make their own decisions regarding exclusion of asymptomatic HCWs based on their local epidemiology and staffing needs consistent with your crisis standards of care and emergency preparedness planning.

   Exclude symptomatic staff immediately. In facilities without active COVID-19 transmission, implement an aggressive strategy to test staff or residents with COVID-19 compatible symptoms for SARS-CoV-2. In facilities with documented on-going transmission, consult DOH for testing recommendations.

5. **Consider All Residents in Units with COVID-19 (+) Residents as Infectious**

In sub-acute care settings consider all residents on the same wing/unit/floor (hereafter referred to as unit) with a COVID-19 positive resident as infectious. Use proper PPE as described in item 8 (below).

A unit would be best defined as one where the staff are not typically shared with other areas during one shift. Recent information about COVID-19 spread in LTCF shows about half of residents testing positive for COVID-19 are not symptomatic. Spread of the virus could have been occurring long before a positive test is reported.

6. **Consider the Utility of Creating a Designated COVID-19 Unit**
   Creating a separate area of the building or a designated unit with the plan to move COVID-19 positive residents there upon diagnosis, may be an option in some facilities. If employed, this strategy must be used in conjunction with maintaining the original unit under all precautions; many residents of that unit might already be COVID-positive.

7. **Dedicate Staff for Affected Units with Confirmed COVID-19**
   Staff who have been working on a unit with a COVID-19 case are already exposed. Whenever possible, those staff should continue to work exclusively in the affected unit. If shared staff working between wings/units is unavoidable, staff should be sure to change all PPE and perform hand hygiene when moving between affected units and units believed to be unaffected. This should be limited to key staff that must cover more than one area (e.g. RNs). Dedicated staff is an important infection prevention measure and PPE optimization strategy.

8. **PPE When Providing Care to COVID-19 (+) Residents**
   Adhere to recommended PPE usage guidelines and optimization strategies to the fullest extent possible. While universal masking is recommended for all staff, when caring for a resident with COVID-19, use a filtering facepiece respirator (e.g., N95 mask) when available, especially when performing aerosol generating procedures.

9. **Bundle Tasks**
   To optimize PPE and limit exposures, consider cross-training to conserve resources and perform multiple tasks during the same patient interaction (e.g., deliver food tray and check vital signs).

10. **Dedicate Equipment**
    Dedicate mobile equipment exclusively to a unit/wing to minimize exposures and transmission throughout a facility and in between facilities.

Categories of Health Alert messages:
Health Alert: conveys the highest level of importance; warrants immediate action or attention.
Health Advisory: provides important information for a specific incident or situation; may not require immediate action.
Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of April 3, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

EXHIBIT G

The Joint Commission

Statement on Universal Masking of Staff, Patients, and Visitors in Health Care Settings
April 23, 2020

On April 13, 2020, the U.S. Centers for Disease Control and Prevention revised its infection prevention and control recommendations related to COVID-19. To address asymptomatic and pre-symptomatic transmission, CDC recommended that healthcare facilities "…implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms…" Source control involves having people wear a cloth face covering or facemask over their mouth and nose to contain their respiratory secretions and thus reduce the dispersion of droplets from an infected individual. This will decrease the possibility that anyone with unrecognized COVID-19 infection will expose others and will allow organizations to forgo contact tracing if a case is identified. For source control to be effective, it requires that everyone wear a mask within healthcare buildings to prevent droplet and (to a lesser degree) aerosol spread of respiratory viruses such as COVID-19.

The Joint Commission supports the CDC's recommendations. The Joint Commission believes that universal masking within healthcare settings is a critical tool to protect staff and patients from being infected by asymptomatic and presymptomatic individuals and should be implemented in any community where coronavirus is occurring. Even a single case of community spread of COVID-19 means that healthcare facilities and staff are at risk because other asymptomatic and presymptomatic patients may come in for care and inadvertently infect staff. This document summarizes key steps and provides materials that may be helpful in implementing this recommendation.

Patients and Visitors

All patients and visitors should be instructed to wear a cloth mask when entering any healthcare building. If they arrive without a cloth mask, one should be provided. If there is a sufficient supply of medical grade facemasks one may be provided instead of a cloth mask. In accordance with CDC recommendations, facemasks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) who are not wearing a mask enter the room. If available, organizations should consider switching patients with respiratory symptoms (e.g., cough or sneeze), including patients with confirmed COVID-19, to a medical grade facemask.

Healthcare Personnel

Facility workers should wear at least a cloth mask when leaving their home, per CDC recommendations. When providing direct patient care to any patient they should don a "medical grade" (official PPE) facemask or respirator depending on the care provided. The CDC says, "Cloth face coverings are not considered PPE because their capability to protect healthcare personnel (HCP) is unknown." **Healthcare personnel who provide support services but do not provide direct patient care should also wear a facemask, but in order to conserve supplies the facemask can be cloth**. Outbreaks of COVID have occurred among healthcare personnel who provide support services.

The Joint Commission

Masks may be removed when social distancing of at least 6 feet is possible (e.g., after entering a private office). In order to ensure staff can take off their masks for meals and breaks, scheduling and location for meals and breaks should ensure the at least a 6-foot distance can be maintained between staff when staff needs to remove their mask.

It is important for healthcare facilities to emphasize that hand hygiene is essential to maintaining employee safety, even if staff are wearing masks. If the facemask is touched, adjusted or removed, hand hygiene should be performed**.**

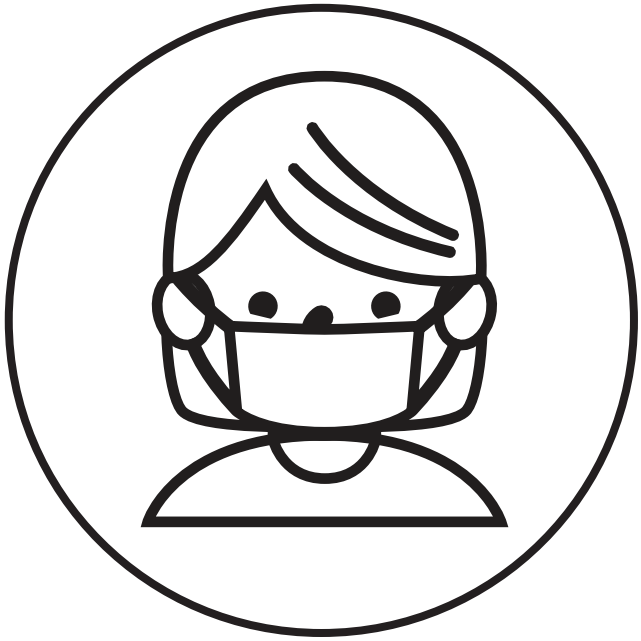
To assist with rapid implementation, we are providing two items which organizations may find helpful. The first is signage that could be posted at entrances to your facility (see attached posters) and an infographic (see attached) that can be used to explain do's and don'ts of wearing a face mask that can be used to educate patients, visitors and staff.

Organizations have done an excellent job communicating policies regarding prior interventions to stop the spread of coronavirus. We encourage organizations to use similar processes to remind patients and visitors that they should be wearing a facemask when they arrive and provide links to CDC resources for making their own sewn or non-sewn masks with materials that are commonly available.

STOP THE SPREAD OF CORONAVIRUS

Wear a mask when you leave home!

- Help protect our healthcare workers by wearing a mask in our building, just as you would anywhere outside your home.
- To help conserve supplies, use cloth or homemade masks when visiting us, performing essential work or errands while also observing social distancing guidelines.



Perform Hand Hygiene when entering and leaving the facility, the patient's room, or your home.

Wash hands with soap and water or clean hands with alcohol-based sanitizer

Modified from CDC.gov

The Joint Commission

STOP THE SPREAD OF CORONAVIRUS

Wear a mask when you leave home!

- Help protect our healthcare workers by wearing a mask in our building, just as you would anywhere outside your home.
- To help conserve supplies, use cloth or homemade masks when visiting us, performing essential work or errands while also observing social distancing guidelines.

Perform Hand Hygiene when entering and leaving the facility, the patient's room, or your home.

Wash hands with soap and water or clean hands with alcohol-based sanitizer

Modified from CDC.gov

The Joint Commission

Do's and Don'ts

Do's and Don'ts for Health Care Staff Wearing Facemasks During the COVID-19 Pandemic*

Do's

- ✓ Wear a cloth or medical facemask whenever you are within 6 feet of other people.
- ✓ Wear a medical facemask as personal protective equipment when providing direct care.
- ✓ Change your facemask if it is damaged (e.g., torn, wet or visibly soiled) or becomes hard to breathe through.
- ✓ Remove ear loop facemasks by handling only the ear loops and tie face masks by handling only the ties.
- ✓ Perform hand hygiene before and after removing a facemask.
- ✓ Practice extended use of disposable medical facemasks (e.g., do not remove mask except to discard) rather than reuse (e.g., remove and store mask between uses) if supplies are limited.
- ✓ In crisis situations, if a facemask must be re-used, store and handle in a manner that prevents contamination of the inside of the mask and wash hands after re-applying.

Don'ts

- ✗ Wear a cloth facemask as personal protective equipment (e.g., when providing direct care to a patient).
- ✗ Remove your mask unless you are at least 6 feet away from other people, this includes co-workers, visitors and patients.
- ✗ Touch the front of a used mask during use or removal.
- ✗ Wear a facemask that is soiled, damaged or hard to breathe through.
- ✗ Wear a medical facemask for aerosol generating procedures (use an N95, Elastomeric, or Powered Air Purifying Respirator for these procedures).
- ✗ Reuse medical facemasks unless the organization has reached crisis situation and has contacted the local health authority and no alternative or additional supplies can be anticipated.

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* Facemasks are just one element that should be used in conjunction with other measures, such as social distancing, to protect people from exposure to COVID-19. When facemasks are worn as PPE they must be used with other PPE as determined by the clinical situation and facility policies and procedures.

EXHIBIT H

PENNSYLVANIA DEPARTMENT OF HEALTH

2020 – PAHAN – 496 – 4-14-ALT

ADVISORY: Universal Message Regarding Cohorting of Residents in Skilled Nursing Facilities

DATE:	4/14/2020
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**ADVISORY: Universal Message Regarding Cohorting of Residents in Skilled Nursing Facilities**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a Health Advisory:

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL**; EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS**: PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF IN YOUR FACILITY

Cohorting of residents with COVID-19 in dedicated units within skilled nursing facilities can be an effective transmission prevention strategy, but it must be done deliberately to be effective.

Once COVID-19 is identified in a nursing care facility, there are three types of residents to consider: confirmed or probable cases, exposed residents, and unexposed residents.

Cohorting decisions should consider all three groups of residents, with the first priority being to restrict the mixing of residents who are cases **or** are exposed with those who are thought to be unexposed.

This HAN provides examples of situations in which cohorting residents or use of a dedicated COVID-19 unit may be beneficial.

The Pennsylvania Department of Health is committed to a unified message regarding cohorting of residents in skilled nursing facilities with cases of COVID-19. Existing guidance regarding cohorting of residents includes CDC guidance for long-term care facilities, CMS guidance for long term care facilities and the PA-HAN 492. These guidance documents have been interpreted in ways that conflict with the intended unified message from the Department. Science behind cohorting is also informed by a recent MMWR publication about asymptomatic and presymptomatic shedding of virus in skilled nursing facilities and communications with CDC and other health jurisdictions regarding experiences in the field.

This unified message has been vetted and agreed upon by the Division of Nursing Care Facilities and the Bureau of Epidemiology. The message provides additional details to supplement the existing guidance in PA-HAN 492.

In most instances, once COVID-19 has been confirmed in a resident of a skilled nursing facility, *it is likely to have already spread to other residents in the unit* where the resident lives. Immediate action according to established guidance is the key to preventing further spread. Cohorting residents is one prevention strategy, but it must be done deliberately to be effective.

Once COVID-19 is identified in a skilled nursing facility, there are three types of residents to consider:

- **Cases:** Those with confirmed or probable COVID-19. This includes residents who were exposed to COVID-19 and are exhibiting symptoms consistent with COVID-19 but have not yet been tested or will not be tested
- **Exposed:** Those who have been exposed to COVID-19 but are not yet exhibiting symptoms
- **Unexposed:** Those who are not known to have not been exposed to COVID-19

Cohorting decisions should consider all three groups of residents. **The primary goal of cohorting is to restrict mixing of residents who are cases or are exposed with those who are thought to be unexposed. Separating cases from exposed residents is a secondary goal of cohorting.**

For all units that house residents who are cases or exposed:

- All recommended PPE (gown, gloves, mask, and eye protection) must be worn per PA-HAN 492.
- Actively monitor all case or exposed residents every 8 hours for fever (T≥100.0ºF) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches).
  - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt further evaluation for COVID-19.
- Dedicate staff to these units. If shared staff working between wings/units is unavoidable, staff should be sure to change all PPE and perform hand hygiene when moving between affected and unaffected units. This should be limited to key staff that must cover more than one area (e.g. RNs).
- If healthcare workers have recovered from COVID-19 infection and meet the requirements for return-to-work outlined by CDC, they should be prioritized to work with case residents. They should continue to wear all recommended PPE. Considerations for return to work sooner under crisis standards should align with CDC recommendations for mitigating staffing shortages.

With regard to moving residents and cohorting residents, it is imperative that facilities follow the guidance in PA-HAN 492. **Consider all residents in units with COVID-19 cases as exposed and potentially infectious.** Recent information about COVID-19 spread in LTCF shows about half of residents testing positive for COVID-19 are not symptomatic. Spread of the virus could have been occurring undetected long before a positive test is reported.

Creating a designated area of the building or a designated unit for COVID-19 positive residents, may be an option in some facilities. If implemented, this strategy must be used in conjunction with maintaining the original affected unit under all previously mentioned precautions; many residents of that unit might already be COVID-positive (even without symptoms).

Examples of When Cohorting may be Beneficial

1. A unit designated for COVID-19 positive residents who are new admissions and were not in the facility prior to hospital admission. Residents would be cared for using all recommended PPE and until they could be removed from transmission-based precautions based on CDC guidance.
2. A unit designated for monitoring of new admissions and readmissions for the first 14 days of their stay. This unit would be for residents with unknown exposure to COVID-19. All recommended PPE should be used for these residents.
3. A COVID-19 positive resident is identified in an extremely high-risk unit, for example in a designated ventilator unit. Moving a resident from a high-risk unit to a designated COVID-19 unit may reduce the *ongoing* risk to other residents in the original unit. Do not move the COVID-19 positive resident to a unit with residents who are unexposed to COVID-19. The original unit must be maintained as above for exposed residents.
4. The first positive COVID-19 resident is identified in a unit where no other residents have symptoms. The facility is able to move this resident to an isolated area of the unit (e.g. end of the hallway) or a designated COVID-19 unit that is not yet in use or contains only COVID-19 cases.
    a. Some facilities have successfully implemented a policy to move the first positive COVID-19 resident from a unit into a dedicated space. This is a reasonable approach if the case is identified early. The original unit must be maintained as above for exposed residents. As more residents become symptomatic or are confirmed positive for COVID-19, the benefit of moving residents is outweighed by the risk.

Examples of When Cohorting has Limited Benefit

1. The first positive COVID-19 resident is identified in a unit where there are also other residents with possible symptoms or several positive residents are identified in the same unit within a few days. This suggests transmission has likely occurred to many others in the unit. Testing of symptomatic residents may be pending or planned. Moving the positive residents to a dedicated unit, even a unit that already has several positive COVID-19 residents, has minimal benefit.
    a. All residents in the original unit must be treated as infectious and cared for using full PPE (gown, gloves, mask, and eye protection) per PA-HAN 492.
    b. In most facilities using this process, newly identified symptomatic residents present over the following week, and moving residents becomes no longer feasible. Urgent room changes may negatively impact the health and well-being of the residents and should occur when benefits outweigh the risk.

Categories of Health Alert messages:
Health Alert: conveys the highest level of importance; warrants immediate action or attention.
Health Advisory: provides important information for a specific incident or situation; may not require immediate action.
Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of April 14, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

EXHIBIT I

PENNSYLVANIA DEPARTMENT OF HEALTH

2020 – PAHAN – 508 – 5-12-ADV

ADVISORY: Test-based Strategies for Preventing Transmission of the Virus that Causes COVID-19 in Skilled Nursing Facilities

DATE:	5/12/2020
TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	**ADVISORY: Test-based Strategies for Preventing Transmission of the Virus that Causes COVID-19 in Skilled Nursing Facilities**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

This transmission is a Health Advisory: provides important information for a specific incident or situation; may not require immediate action.

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- Universal testing of residents and staff is one strategy to help inform infection prevention and control in skilled nursing facilities.
- Consider four key principles when using testing in skilled nursing care facilities.
  - Testing should not supersede existing infection prevention and control (IPC) interventions.
  - Testing should be used when results will lead to specific IPC actions.
  - The first step of a test-based prevention strategy should ideally be a point prevalence survey (PPS) of all residents and all HCP in the facility.
  - Repeat testing may be warranted in certain circumstances.
- Facilities should develop a plan for testing and post-testing intervention to include:
  - Logistics of resident and staff testing
  - Cohorting plan to include designated Red, Yellow, and Green zones, respective of testing result and exposure status.

Nursing home populations are at high risk for infection, serious illness, and death from COVID-19. Testing is one strategy to help inform prevention and control in the facility. The Department has developed these guidelines to expand upon CDC Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes. If you have questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

KEY TERMS:

Testing or test: Laboratory tests that detect SARS-COV-2, the virus that causes COVID-19, using reverse transcription polymerase chain reaction (RT-PCR) testing are referred to here as testing or test.

SARS-CoV-2 infection: A term used throughout this document to indicate any person with a positive PCR test for SARS-CoV-2, regardless of whether they have symptoms or are asymptomatic. Persons with symptoms and a positive test are said to have COVID-19.

Healthcare personnel (HCP): Include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Consider the following four key principles when using testing in nursing homes:

1. Testing should not supersede existing infection prevention and control (IPC) interventions.

Testing conducted at nursing homes should be implemented *in addition to* existing infection prevention and control measures recommended by the DOH, including visitor restriction, cessation of communal dining and group activities, monitoring all HCP and residents for signs and symptoms of COVID-19, and universal masking as source control. See PA-HAN-497 for more details about infection prevention and control and PA-HAN-500 for guidance about specimen collection.

2. Testing should be used when results will lead to specific IPC actions.

For example, test results can be used to:

- Cohort exposed residents to separate those with SARS-CoV-2 infection from those without detectable SARS-CoV-2 infection at the time of testing to reduce the opportunity for further transmission.
- Determine the SARS-CoV-2 burden across different units or facilities and allocating resources.
- Identify HCP with SARS-CoV-2 infection for work exclusion.
- Enable HCP to return to work after being excluded for SARS-CoV-2 infection.
- Discontinue transmission-based precautions for residents with resolved SARS-CoV-2 infection.

3. The first step of a test-based prevention strategy should be a point prevalence survey (PPS), ideally, of all residents and all HCP in the facility.

Testing of residents

Testing of residents should be aligned with consideration for testing capacity in the following order of priority:

1. Facility-wide PPS of all residents should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience from nursing homes with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic

residents with SARS-CoV-2 present as well. PPS of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility. If undertaking facility-wide PPS, facility leadership should be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them.
    - If testing capacity is not sufficient for facility-wide PPS, performing PPS on **units with symptomatic residents** should be prioritized.
    - If testing capacity is not sufficient for unit-wide PPS, testing should be prioritized for **symptomatic residents and other high-risk residents**, such as those who are admitted from a hospital or other facility, roommates of symptomatic residents, or those who leave the facility regularly for dialysis or other services.
2. In facilities that do not have known cases of COVID-19, test 20% of residents weekly to identify early transmission. If any testing from the sample population is positive, the facility should plan to do facility-wide testing.

Testing of nursing home HCP

Testing of staff should be aligned with consideration for testing capacity in the following order of priority:

1. PPS of **all HCP** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well. HCP likely contribute to introduction and further spread of SARS-CoV-2 within nursing homes.
2. In facilities that do not have known cases of COVID-19, test 20% of staff weekly to identify early transmission. If any testing from the sample population is positive, the facility should plan to do facility-wide testing.

CDC recommends **HCP with COVID-19 be excluded from work**. Follow PA-HAN-501 for Return-to-Work Guidance. Facility leadership should have a plan for meeting staffing needs to provide safe care to residents while infected HCP are excluded from work. If the facility is in Crisis Capacity and facing staffing shortages, see CDC guidance on Strategies to Mitigate Healthcare Personnel Staffing Shortages for additional considerations.

4. Repeat testing may be warranted in certain circumstances.

Initial PPS should be prioritized; repeat testing should be aligned with consideration for testing capacity. After initial PPS has been performed for residents and HCP (baseline) and the results have been used to implement resident cohorting and HCP work exclusions, nursing homes may consider retesting under the following circumstances:

Retesting of residents

- Retest any resident who develops symptoms consistent with COVID-19.
    - Consider retesting all residents who previously tested negative at some frequency shortly (e.g., 3 days) after the initial PPS, and then weekly to detect those with newly developed infection; consider continuing retesting until PPSs do not identify new cases.
    - DO NOT DELAY TESTING of symptomatic individuals until the next scheduled facility-wide testing event.

  - If testing capacity is not sufficient for retesting all residents, retest those who frequently leave the facility for dialysis or other services and those with known exposure to infected residents (such as roommates) or HCP.
- Use retesting to inform decisions about when residents with COVID-19 can be moved out of COVID-19 wards. See PA-HAN-502 for additional information.

Retesting of nursing home HCP

- Retest any HCP who develop symptoms consistent with COVID-19.
- Retest to inform decisions about when HCP with COVID-19 can return to work. Follow PA-HAN-501 for Return-to-Work Guidance.
- Consider retesting HCP at some frequency based on community prevalence of infections (e.g., once a week).

If testing capacity is not sufficient for retesting all HCP, consider retesting HCP who are known to work at other healthcare facilities with cases of COVID-19.

Facilities Should Develop a Plan for Testing and Post-Testing Intervention

Planning for Testing Logistics:

- Which asymptomatic residents will be tested? (all *symptomatic* residents should be tested)
- Which HCP should be tested?
- Which laboratory will provide collection materials and process specimens? Ideally, laboratories reporting results within 1-2 days should be used. Longer turn-around-times severely limits the utility of testing asymptomatic persons.
  - While testing can be completed at the state public health laboratory where timely commercial testing is not available, the large scope of the pandemic will require facilities to use their own resources to obtain testing results more rapidly.
  - Facilities should develop relationships with commercial laboratories for testing (including acquisition of supplies).
  - Facilities who cannot acquire testing supplies or who want to perform an initial PPS using the state public health laboratory should contact RA-DHCOVIDTESTING@pa.gov with the facility name in the subject.
- Who will obtain patient agreement and how will it be documented? DOH recommends using the same process as would be used for influenza testing or other related laboratory tests.
- Who will perform specimen collection?
- What PPE will be worn during testing and how often will it be changed?
  - The DOH recommends staff collecting swabs wear gowns, gloves, eye protection and respirators or facemasks, if respirators are not available. Gowns, eye protection and respirators or facemasks should be changed if coughed or sneezed upon or if otherwise soiled. Gloves must be changed between each test with hand hygiene performed with each glove change.
- What shipping supplies and refrigeration are needed?

Post-Testing Actions to Prevent Transmission:

For resident testing:

- Residents need to be cohorted to separate units in three zones, based on test results.
  - **COVID + test (Red Zone)**: residents with a positive SARS-CoV-2 PCR test and still within the parameters for transmission-based precautions

- **COVID – test potentially exposed (Yellow Zone):** residents with a negative SARS-CoV-2 PCR test who remain asymptomatic but are within 14 days of possible exposure to COVID-19
- **Unexposed (Green Zone):** any resident in the facility who was not tested and is thought to be unexposed to COVID-19

- The three types of residents listed above should not share common areas such as communal bathrooms and showers with other types of residents. The three zones should remain separate on the unit.
- Staff should be designated by zone *as much as possible* to minimize risk to exposed (Yellow) and non-exposed (Green) residents. Using staff in more than one zone should be prioritized as below, with the best option listed first, and the least desirable option last.

Best Option	Staff always work on the same unit, and units do not include more than one Zone. Staff do not cross over to other units.
	Staff always work on the same Zone, and do not cross over to other Zones. They may work in two or more exposed (Yellow) units, for example.
	Staff are assigned to specific Zones but must *occasionally* cover staffing needs in other Zones for certain shifts. Ideally, staff would not work in the COVID-positive (Red) unit and then return to exposed (Yellow) or unexposed units (Green).
	Staff always work in the same Zone during one shift but may work in different Zones on different shifts. Ideally, staff would not work in the COVID-positive (Red) zone and then return to exposed (Yellow) or unexposed (Green) units.
Least Desirable	Occasionally staffing needs require that certain staff work in more than one Zone during a single shift. That person must change all PPE and perform hand hygiene when going from one Zone unit to another. *Exception: respirators or facemasks that have been worn with a face shield can be worn continuously.* Ideally, this should be limited to key staff (e.g. RNs).

Zone Guidelines

- Zones should be clearly marked with limited access signs or temporary barriers to prevent unnecessary foot traffic to the area.
- Equipment should be dedicated ideally to each unit, and if necessary shared only between units of the same Zone. Any equipment that must be shared between

different Zones should be fully cleaned and disinfected between use. These occurrences should be rare.

- Full PPE must be used to care for residents in COVID+ (Red) and COVID- potentially exposed (Yellow) zones.
- COVID Positive (Red) and Unexposed (Green) units should be as far apart as possible within the facility.
- Unexposed (Green) units should be clearly marked with limited access signs or temporary barriers to prevent unnecessary foot traffic to the area.
- Occasionally, a laboratory may report an **inconclusive or indeterminant result** for SARS-CoV-2 PCR testing. For residents with these results, specimen collection should be repeated as soon as possible. The resident should be cared for within a COVID-potentially exposed (Yellow) zone while awaiting repeat test results.
- **Any resident who develops symptoms consistent with COVID, should be presumed positive**
  - Test for COVID-19 immediately if symptoms occur.
  - While awaiting test results, move to a private room or remove roommate from current room. Consider roommate exposed (Yellow). Keep resident in current unit if they are in an Exposed unit (Yellow). If the symptomatic resident is in an Unexposed (Green) zone, move to the Exposed (Yellow) zone in a private room.
  - If test positive, move to COVID Positive zone (Red).
- **De-escalating Zones:** When criteria set forth in PA-HAN-502 under "Discontinuing 'exposed' or 'affected' status for a unit or facility" are met:
  - A COVID Positive zone (Red) may be changed to Unexposed (Green) status
  - A COVID-potentially exposed (Yellow) Zone may be changed to Unexposed (Green) status where these criteria have been met and where exposure occurred at least 14 days ago.
- **Residents refusing testing**: occasionally asymptomatic residents may refuse to be tested. These residents, if potentially exposed to COVID-19, should be cared for in a COVID- potentially exposed (Yellow) zone until at least 14 days after exposure. If these residents develop fever or respiratory symptoms testing is recommended, and the testing request should be re-visited with the resident or responsible party.

For staff testing:

- Follow PA-HAN-501 for Return-to-Work Guidance.
  a. Staff with fever or respiratory symptoms should be excluded from work and isolated until they meet return to work criteria.
  b. Asymptomatic staff who test positive should be excluded from work and isolated for 10 days from the date of their first positive test (if they have not developed symptoms). *See exception for critical staffing needs below.*
- *Exceptions for critical staffing need*- Asymptomatic staff may be able to work, but facilities must ensure the following conditions exist prior permitting these staff to work:
  a. Asymptomatic staff with SARS-CoV-2 infection must only work with COVID-19 positive residents (Red Zone) and staff.
  b. Work areas for COVID positive and negative or untested staff must be kept separate, including break rooms, workstations and bathrooms.

If you have questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

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This information is current as of May 12, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.

EXHIBIT J

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DEPARTMENT OF HEALTH

May 12, 2020

Interim Guidance for Nursing Care Facilities During COVID-19

The Department of Health (Department) is providing the below guidance as an update to the guidance issued on March 18, 2020. Since the previous version of the guidance, the Department has issued several Health Alert Networks (HANs), which require greater detail in guidance for nursing care facilities (NCFs) regarding personnel allowed to access the facility amid visitor restrictions; health care personnel who become ill during their shift; admissions and readmissions for residents exposed to COVID-19; and testing for COVID-19 upon discharge from a hospital to an NCF. As well, the epidemiological understanding of COVID-19 has deepened, which resulted in a new section around cohorting residents, and the Secretary of Health issued an Order requiring facilities to report in Knowledge Center so the Department may have more real-time information in order to best serve facilities.

1. Admissions/Readmissions

All admissions and readmissions to NCFs must follow HAN 502 for Transmission-Based Precautions. Given the significant risk COVID-19 poses to residents of NCFs, the following guidelines should be followed related to admission and readmission of residents:

NCF Resident At Hospital for COVID-19 - Per HAN 502, if Transmission-Based Precautions are still required, the resident should be readmitted to an NCF with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients, and preferably be placed in a location designated to care for COVID-19 residents. - *NOTE*: Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for readmission. - If resident has already tested positive for COVID-19, do not test again as a condition for readmission. - A positive test result is not a reason to refuse readmission to a resident; rather, adhere to HAN 502.	**NCF Resident at Hospital for Anything Other than COVID-19** - Hospital should test the patient before discharge to an NCF to ensure the patient is not asymptomatic or pre-symptomatic positive. NCFs may refuse to admit a patient if a test is not administered. - NCFs should not wait until test results are available before readmission if the resident is clinically indicated for discharge, but should be prepared to quarantine a resident until test results are available. - A positive test result is not a reason to refuse readmission to a resident; rather, adhere to HAN 502.
Individual at Hospital for COVID-19 Being Discharged to NCF - Per HAN 502, if Transmission-Based Precautions are still required, the individual should go to an NCF with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients, and preferably be placed in a location designated to care for COVID-19 residents.	**Individual at Hospital for Anything Other than COVID-19 Being Discharged to NCF** - Hospital should test individual before discharge to a NCF to ensure patient is not asymptomatic or pre-symptomatic positive. NCFs may refuse to admit a patient if a test is not administered.

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- *NOTE*: Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge. - If individual has already tested positive for COVID-19, do not test again as a condition for admission. - A positive test result is not a reason to refuse admission to an individual; rather, adhere to HAN 502. - An NCF must continue to take new admissions, if appropriate beds are available, and a suspected or confirmed positive for COVID-19 is not a reason to deny admission.	- NCFs should not wait until test results are available before admission if the individual is clinically indicated for discharge, but should be prepared to quarantine the individual until test results are available. - A positive test result is not a reason to refuse admission to an individual; rather, adhere to HAN 502. - NCF must continue to take new admissions, if appropriate beds are available.

2. Cohorting Residents

If an NCF wishes to expand the number of beds or convert closed wings or entire facilities to support COVID-19 patients or residents, first review PA-HAN 496, Universal Message Regarding Cohorting of Residents in Skilled Nursing Facilities. If the facility's planned strategy appears to conform with PA-HAN 496, submit a request to the Department's appropriate field office for approval. Each request will be considered on a case-by-case basis, and dialogue with the facility will occur to acquire all details needed for the Department to render a decision. To ensure the Department has the necessary information to enter into that dialogue, include at a minimum the following information for the new or expanded space (if applicable) with the request:

- Number of beds and/or residents impacted, including whether residents will be moved initially.
- Whether the beds are Medicare or Medicaid (including proof of approval from the Department of Human Services to expand the number of Medical Assistance beds, if applicable).
- Location and square footage (with floor plan and pictures, if appropriate).
- Available equipment in the room.
- Staffing levels and plan for having adequate staffing for the duration of the cohorting.
- Plan for locating displaced residents including care of vulnerable residents (such as dementia residents) either in the same facility or sister facility.
- Description of how residents with COVID-19 will be handled (e.g., moving within the facility, admitted from other facilities, admitted from the hospital).
- Plan for discontinuing use of any new, altered or renovated space upon the expiration of the Governor's Proclamation of Disaster Emergency issued on March 6, 2020.
- Contact information for person responsible for the request.

Upon submission of the request, a representative from the Department will reach out to the facility's contact person to discuss next steps. Questions regarding this process can be directed to the appropriate field office.

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3. Mandatory Reporting through Knowledge Center

In accordance with the Order of the Secretary of Health issued on April 21, 2020, all NCFs licensed in the Commonwealth must complete the Nursing Care Facility Survey in the Knowledge Center at 8:00 a.m. daily. All fields indicated as mandatory must be completed. If any non-mandatory field has changed from the initial submission, the facility must update that field on the next calendar day's submission.

4. Visitors Policies

NCFs should limit outside visitors to the greatest extent possible to limit exposure for residents; however, there are some instances when visitation is necessary, which is outlined below. All visitors who enter the facility must adhere to universal masking protocols in accordance with HAN 492 and HAN 497. The following specific examples of inappropriate and appropriate visitation include:

1. Restrict all visitors, except those listed in the fourth bullet point below.

2. Restrict all volunteers, non-essential health care personnel and other non-essential personnel and contractors (e.g., barbers).

3. Restrict cross-over visitation from personal care home (PCH), Assisted Living Facility, and Continuing Care Community residents to the NCF. Ensure cross-over staff adhere to the facility's infectious disease protocol.

4. The following personnel are exempt from visitor restrictions and are therefore permitted to access NCFs:

    - Physicians, nurse practitioners, physician assistants, and other clinicians;
    - Home health and dialysis services;
    - The Department of Aging/Area Agency on Aging and the Department of Human Services *where there is concern for serious bodily injury, sexual abuse, or serious physical injury*; and
    - Hospice services, clergy and bereavement counselors, offered by licensed providers within the NCF, as well as the Department of Health or agents working on behalf of the Department, or local public health officials.

5. Infection Control and Personal Protective Equipment (PPE)

- The infection control specialists designated by the facility must review PPE guidelines with all staff.
- Residents may not engage in communal activities until their Region is designated as Green, per the Governor's guidance.
- Minimize resident interactions with other personnel and contractors performing essential services (e.g., plumbers, electricians, etc.) through actions such as using separate

entrances, performing service at off-hours, and performing only essential servicing activities.

- Arrange for deliveries to areas where there is limited person-to-person interaction.
- Evaluate environmental cleaning practices and increase frequency of cleaning and disinfection for high-touch surfaces.
- Refer to the following for guidance on infection control and PPE use, including universal masking for all persons entering the facility:
  - HAN 497 Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (COVID-19) in a Healthcare Setting
  - HAN 492, Universal Masking of Healthcare Workers and Staff in Congregate Care Settings

6. Screening

Continue active screening of residents and health care personnel for fever and respiratory symptoms (using a checklist for employees such as the one developed by the American Health Care Association and the National Center for Assisted Living). Staff should be screened at the beginning and end of every shift. All other personnel who enter the facility should be screened.

Health care personnel with even mild symptoms of COVID-19 should consult with occupational health before reporting to work. If symptoms develop while working, health care personnel must cease resident care activities and leave the work site immediately after notifying their supervisor or occupational health services, in accordance with facility policy.

7. Dining Services

- Provide in-room meal service for residents who are assessed to be *capable of feeding themselves* without supervision or assistance.

- Identify *high-risk choking residents and residents at-risk for aspiration* who may cough, creating droplets. Meals for these residents should be provided in their rooms with assistance. If meals cannot be provided in their rooms, the precautions outlined below must be taken for eating in a common area in addition to ensuring the residents remain at least six feet or more from each other.

- *Residents who need assistance with feeding* and eat in a common area should be spaced apart as much as possible, ideally six feet or more. Where it is not possible to have these residents six feet apart, then no more than one resident who needs assistance with feeding may be seated at a table (assuming a standard four-person table).

Precautions When Meals Are Served in a Common Area
➢ Stagger arrival times and maintain social distancing; ➢ Increase the number of meal services or offer meals in shifts to allow fewer residents in common areas at one time;

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- Take appropriate precautions with eye protection and gowns for staff feeding the resident population at high-risk for choking, given the risk to cough while eating; and
- Staff members who are assisting more than one resident at the same time must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents.

This guidance is intended to assist with NCFs' response to COVID-19. With the Governor's authorization as conferred in the disaster proclamation issued on March 6, 2020, all statutory and regulatory provisions that would impose an impediment to implementing this guidance are suspended. Those suspensions will remain in place while the proclamation of disaster emergency remains in effect.

This updated guidance will be in effect **immediately** and through the duration of the Governor's COVID-19 Disaster Declaration. The Department may update or supplement this guidance as needed.

RESOURCES

Department's Guidance, FAQs, and Orders for Nursing Care Facilities:
https://www.health.pa.gov/topics/disease/coronavirus/Pages/Nursing-Homes.aspx
Department's Health Alerts, Advisories, and Updates:
https://www.health.pa.gov/topics/prep/PA-HAN/Pages/2020-HAN.aspx

EXHIBIT K

pennsylvania
DEPARTMENT OF HEALTH

Order of the Secretary of the Pennsylvania Department of Health Requiring Skilled Nursing Facilities to Report Data

COVID-19 is a contagious disease that is rapidly spreading from person to person. People infected are capable of exposing others to COVID-19 even if their symptoms are mild, such as a cough, or even if they are asymptomatic. Additionally, exposure is possible by touching a surface or object that has the virus on it and then touching one's mouth, nose, or eyes. Symptoms of COVID-19 may include fever, cough, shortness of breath, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or small. Early symptoms may also include chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose. Older adults and people who have serious chronic medical conditions are at a higher risk for serious illness.

Many places in the Commonwealth are continuing to experience "community spread" of COVID-19, which means that the illness is being transmitted through unknown sources, not from known areas of infection. Mass gatherings increase the risk of transmission and community spread.

On March 6, 2020, the Governor issued a Proclamation of Disaster Emergency due to the emergency of COVID-19 in the United States and the Commonwealth of Pennsylvania. Since the Commonwealth of Pennsylvania confirmed its first case of COVID-19, the number of positive cases has continued to rise. Case counts rapidly increased throughout the Commonwealth in March and April, 2020. As of May 12, 2020, every county in the Commonwealth has been affected, the number of cases is 57,991 and 3806 individuals have died from the virus.

In order to slow the spread and protect the people of the Commonwealth, the Governor and I issued orders on March 19, 2020, closing all Commonwealth businesses that are not life sustaining. *See Order of the Governor of the Commonwealth of Pennsylvania Regarding the Closure of All Businesses That Are Not Life Sustaining,* as amended; *Order of the Secretary of the Pennsylvania of Health Regarding the Closure of All Businesses That Are Not Life Sustaining,* as amended. On April 1, 2020, the Governor and I issued orders directing all individuals in Pennsylvania to stay at home. *See Order of the Governor of the Commonwealth of Pennsylvania for Individuals to Stay at Home,* as amended; *Order of the Secretary of the Pennsylvania Department of Health to Stay at Home,* as amended. Those mitigation efforts slowed the spread of the disease, protected our hospitals from being overwhelmed, and enabled our hospitals to care for our ill residents. Accordingly, in an order issued on May 8, 2020, the Governor and I suspended restrictions for certain areas instituted in the orders of March 19, 2020, as amended, and April 1, 2020, as amended. *See Order of the Governor of the Commonwealth of*

Pennsylvania for Limited Opening of Business, Lifting of Stay at Home Requirements, and Continued Aggressive Mitigation Efforts; Order of the Secretary of the Pennsylvania Department of Health for a Limited Opening of Businesses, Lifting of Stay Home Requirements and Continued Aggressive Mitigation Efforts.

While there has been success in the mitigation strategies practiced by all persons in the Commonwealth and the overall number of new cases continues to slow, person-to-person spread among residents of congregate care homes, including skilled nursing facilities, continues. The spread of COVID-19 is occurring despite the best efforts of public health and other officials and personnel to mitigate and control the spread within these facilities. To further assist the Department in determining and employing the most efficient and practical means for prevention and suppression of COVID-19 within skilled nursing facilities, it is necessary for the Department to have all available and current information. Maintaining a consistent and constant flow of information between skilled nursing facilities and the Department is essential in managing the spread of COVID-19 within these facilities and to protect the health and safety of all persons in the Commonwealth.

COVID-19 is a threat to the public's health, for which the Secretary of Health may order general control measures, including, but not limited to, closure, isolation, and quarantine. This authority is granted to the Secretary of Health pursuant to Pennsylvania law. *See* Section 5 of the Disease Prevention and Control Law, 35 P.S. § 521.5; sections 2102(a) and 2106 of the Administrative Code of 1929, 71 P.S. §§ 532(a), and 536; and the Department of Health's (Department's) regulations at 28 Pa. Code §§ 27.60-27.68 (relating to disease control measures; isolation; quarantine; movement of persons subject to isolation or quarantine; and release from isolation and quarantine). Particularly, the Department has the authority to take any disease control measure appropriate to protect the public from the spread of infectious disease. *See* 35 P.S. § 521.5; 71 P.S. § 532(a), and 1402(a); 28 Pa. Code § 27.60.

Additionally, pursuant to the regulations promulgated under the Health Care Facilities Act, 35 P.S. § 448.801-904(b), long-term care facilities, such as skilled nursing facilities, are required to comply with applicable state laws. *See* 28 Pa. Code § 201.13(g). Nursing care facilities must maintain minimum standards as set by the Department. *See* 28 Pa. Code § 201.14(a). Maintaining minimum standards requires following any disease control measure ordered by the Secretary of Health under the authority afforded to her by statute and regulation.

Accordingly, on this date, May 14, 2020, under the authority granted to me by law and to protect the public from the spread of COVID-19, I hereby order:

Section 1: Skilled Nursing Facilities Reporting of Data to the Department.

A. Effective May 16, 2020, all skilled nursing facilities licensed in this Commonwealth shall begin reporting in the system designated by the Department all data required by the Centers for Medicaid & Medicare Services (CMS) to be

reported to the Centers for Disease Control and Prevention (CDC). *See* 42 CFR § 483.80(g) (relating to infection control); *see also* QSO-20-29-NH (Memorandum from the Director of the Quality, Safety and Oversight Group of the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group of CMS regarding: Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes).

B. Following the first report of data, which shall be submitted to the Department no later than 11:59 p.m., May 16, 2020, reporting of data shall continue daily on each subsequent date a facility reports to the CDC until this order is suspended.

Sections 2: This Order shall take effect at 12:01 a.m. on May 16, 2020.

Rachel Levine, MD
Secretary of Health

EXHIBIT L

pennsylvania
DEPARTMENT OF HEALTH

Order of the Secretary of the Pennsylvania Department of Health Directing Testing at Skilled Nursing Facilities

COVID-19 is a contagious disease that is rapidly spreading from person to person. People infected are capable of exposing others to COVID-19 even if their symptoms are mild, such as a cough, or even if they are asymptomatic. Additionally, exposure is possible by touching a surface or object that has the virus on it and then touching one's mouth, nose, or eyes. Symptoms of COVID-19 may include fever, cough, shortness of breath, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell. Early symptoms may also include chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose. Older adults and people who have serious chronic medical conditions are at a higher risk for serious illness.

The first cases of COVID-19 were reported in the United States in January, 2020. Since then, multiple areas of the United States have experienced "community spread" of COVID-19, meaning that the illness is being transmitted through unknown sources, and not from known areas of infection. On March 6, 2020, after the first cases of COVID-19 in the Commonwealth of Pennsylvania were confirmed, the Governor issued a Proclamation of Disaster Emergency. Since that date, the number of positive cases has continued to rise, and community spread has continued in the Commonwealth as well. Case counts rapidly increased throughout the Commonwealth in March and April, 2020. As of June 8, 2020, every county in the Commonwealth has been affected, the number of positive cases is 75,943 and 5,953 persons have died from COVID-19.

In order to slow the spread of COVID-19 and protect the people of the Commonwealth, the Governor and I issued orders on March 19, 2020, closing all Commonwealth businesses that are not life sustaining. *See Order of the Governor of the Commonwealth of Pennsylvania Regarding the Closure of all Businesses that are Not Life Sustaining of March 19 ,2020,* as amended; *Order of the Secretary of the Pennsylvania of Health Regarding the Closure of all Businesses That Are Not Life Sustaining* of March 19, 2020, as amended (Orders of March 19, 2020, as amended). On April 1, 2020, the Governor and I issued Orders directing all individuals in Pennsylvania to stay at home. *See Order of the Governor of the Commonwealth of Pennsylvania for Individuals to Stay at Home* of April 1, 2020, as amended; *Order of the Secretary of the Pennsylvania Department of Health to Stay at Home* of April 1, 2020, as amended. These mitigation efforts have slowed the spread of the disease, and have protected our health care system from being overwhelmed. Accordingly, in our Orders of May 7, 2020, the Governor and I suspended restrictions for certain areas instituted in the Orders of March 19, 2020, as amended, and April 1, 2020, as amended. *See Order of the Governor of the Commonwealth of Pennsylvania for Limited Opening of Business, Lifting of Stay at Home Requirements, and Continued Aggressive Mitigation Efforts, as amended; Order of the Secretary of the Pennsylvania Department of Health for a Limited Opening of Businesses, Lifting of Stay Home Requirements and Continued Aggressive Mitigation Efforts, as amended.*

While these mitigation strategies, practiced by all persons in the Commonwealth, have been successful, and the overall number of new cases continues to decline, allowing the phased and considered reopening of the Commonwealth, *see Order of the Governor For the Continued Reopening of the Commonwealth, Order Of the Secretary for the Continued Reopening of the Commonwealth, as amended*, person-to-person spread among residents and staff of skilled nursing facilities (SNF) continues. Further, residents of congregate care homes, because of age, or co-morbidities, or both, are extremely susceptible to COVID-19. Contracting the virus can result in these persons developing pneumonia or other severe acute respiratory and cardiac issues, among other concerns. Despite the best efforts of public health officials and others to mitigate and control the spread of COVID-19 and the concomitant danger to residents and staff within these facilities, and in the community, the virus is still spreading. Early identification of infected facility residents and staff, while difficult due to asymptomatic spread of the virus, can help to limit the spread of the virus among these vulnerable residents, the staff that is caring for them, and the communities in which they live.

COVID-19 is a threat to the public's health, for which the Secretary of Health may order general control measures, including, but not limited to, closure, isolation, and quarantine. This authority is granted to the Secretary of Health pursuant to Pennsylvania law. *See* Section 5 of the Disease Prevention and Control Law, 35 P.S. § 521.5; sections 2102(a) and 2106 of the Administrative Code of 1929, 71 P.S. §§ 532(a), and 536; and the Department of Health's (Department's) regulations at 28 Pa. Code §§ 27.60-27.68 (relating to disease control measures; isolation; quarantine; movement of persons subject to isolation or quarantine; and release from isolation and quarantine). Particularly, the Department has the authority to take any disease control measure appropriate to protect the public from the spread of infectious disease. *See* 35 P.S. § 521.5; 71 P.S. § 532(a), and 1402(a); 28 Pa. Code § 27.60.

Given the continued spread of COVID-19 in the Commonwealth and its danger to Pennsylvanians, and given the vulnerability of residents in skilled nursing facilities, the likelihood of asymptomatic spread in such facilities, and the spread from those facilities back into the community, I have determined that the testing of residents and staff in such facilities is an essential disease control measure to protect the health and safety of all persons in the Commonwealth of Pennsylvania.

Accordingly, on this date, June 8, 2020 to protect residents and staff of skilled nursing facilities and the general public from the spread of COVID-19, I hereby order:

Section 1: Universal Testing for COVID-19 at Skilled Nursing Facilities

A. Each SNF in the Commonwealth shall test residents and staff for COVID-19 in accordance with the Department's Facility Testing Requirements that the Department will publish on or before June 8, 2020, and any future modifications to those requirements. Those Facility Testing Requirements are incorporated herein and made a part of this Order as of the date of their issuance, along with any modification thereto.

B. SNFs required to test under this Order shall have tested all residents and staff at least once by July 24, 2020.

Section 2: Testing Collection and Diagnostic Testing

Specimens collected in accordance with this Order must be submitted to a laboratory approved by the State Public Health Laboratory to perform diagnostic COVID-19 testing, or to the State Public Health Laboratory with the prior approval of the Department.

Section 3: SNF Reporting

A. Unless stated otherwise in the Facility Testing Requirements, each SNF shall report COVID-19 test results by individual, along with any metric required in the Facility Testing Requirements in a manner and through a system designated by the Department.

B. Each SNF shall notify the Department of completion of its initial test of all residents and staff within 48 hours of the SNF's receipt of the test results. An SNF that conducted universal testing prior to this Order shall report the results to the Department in accordance with subsection (A) within 72 hours of the Department's issuance of this Order.

C. Each SNF shall immediately notify the Department of any assistance needed to comply with the Facility Testing Requirements in a manner and through a system designated by the Department.

Section 4: Right of Individual to Refuse Testing

Nothing in this Order shall be read to prevent a resident or a member of the staff of an SNF from refusing testing. Any resident or member of the staff who does not consent to testing shall be treated in accordance with the Facility Testing Requirements.

Section 5: Effective Date.

This Order shall take effect at 12:01 a.m. on June 9, 2020.

Rachel Levine, MD
Secretary of Health